Medicare and Medicaid Managed Care and the Provider’s Role in Compliance

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History

- Managed care program for Medicare

- **Medicare + Choice** established by Balanced Budget Act of 1997

- **Medicare Advantage** renaming in Medicare Modernization Act of 2003
Medicare Advantage from Enrollee’s Perspective

- Individual Medicare member has option of enrolling with private health plan (who has contract with CMS) to receive Medicare benefits
  - Co-pays and deductibles tend to be lower
  - Added benefits (supplemental benefits, such as dental, vision, case management, disease management, nurse call lines)
  - Prescription drug coverage is usually included
  - Can be additional premiums, particularly for optional supplemental benefits, like gyms
Medicare Advantage Enrollment, 1999-2009

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medicare Advantage</th>
<th>Private Fee-for-Service</th>
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<tbody>
<tr>
<td>1999</td>
<td>6.9</td>
<td></td>
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<tr>
<td>2000</td>
<td>6.8</td>
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<td>2001</td>
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<td>2002</td>
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<td>2003</td>
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<td>2004</td>
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<td>2005</td>
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<td>2.3</td>
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<tr>
<td>2009</td>
<td>10.8</td>
<td>2.4</td>
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NOTE: Includes local HMOs, PSOs, and PPOs, regional PPOs, PFFS plans, Cost contracts, Demonstrations, HCPP, and PACE contracts.

Types of Medicare Advantage Plans

- Local HMOs and PPOs
- Private Fee-For-Service plans (PFFS)
- Special Needs Plans (SNPs)
- Regional PPOs
- Other
  - Cost plans
  - HCPP
  - PACE plans
  - Medical savings account
  - Demonstrations and pilots
• **Benchmark** is the maximum amount Medicare will pay in a given area
• **Plan bid** is the estimated costs per enrollee for Part A and Part B (traditional Medicare) services
**Current System for Benchmarks**

Plan bid < benchmark = plan receives 75% of difference as “rebate” which must be used to provide supplemental benefits

Plan bid > benchmark = enrollees pay the difference as well as the premium
Original Goals of Program

• Original goal of Medicare Advantage program: reduce Medicare costs

• Over time, goals became increasing enrollment in private plans and providing extra benefits
Medicare Advantage Payments Relative to Traditional Fee-for-Service Medicare, 2009

Medicare Advantage Plan Types

- Traditional Fee-for-Service Medicare: 100%
- All Medicare Advantage Plans: 114%
- Local HMOs: 113%
- Local PPOs: 118%
- Regional PPOs: 112%
- Private Fee-For-Service Plans: 118%
- Special Needs Plans: 116%

NOTE: HMO is health maintenance organization; PPO is preferred provider organization.

Health Reform Law (PPACA)

- Reduces benchmarks such that amount paid will range from 95% to 115% of Medicare fee-for-service
- Institutes quality bonus payments
- Expands Recovery Audit Contracting program to Medicare Advantage
- Estimated reduction of MA payments for 2010-2019: $138 billion (CBO) to $145 billion (CMS)
New Quality Ratings System

- Five star ratings system based on standard performance measures derived from four sources
  - Healthcare Effectiveness Data and Information Set (HEDIS)
  - The Consumer Assessment of Healthcare Providers and Systems (CAHPS)
  - The Health Outcomes Survey (HOS)
  - CMS administrative data
CMS Administrative Data

- Member satisfaction and disenrollment
- Plan’s appeal processes
- Audit results
- Customer service
- May encompass:
  - Staying healthy including vaccines, screenings, tests
  - Managing chronic conditions
  - Ratings of plan’s responsiveness and care
New Payment Merges Quality Measures and Benchmarks

• If 4 or more stars, quality based bonuses of 1.5% in 2012

• If bid < benchmark and 4.5 to 5 stars, then plan will retain 70% as rebate

• If bid < benchmark and 3.5 to 4 stars, then plan will retain 65% as rebate

• If below benchmark and 3 to 3.5 stars, then plan will retain 50% as rebate

• 2012 quality based payments based on the quality ratings for the 2011 plan year

(Reminder: Current payment system allows 75% rebate if bid < benchmark)
Plans Oversight for Medicare Advantage

- MA plans “maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS” 42 CFR 423.505(i)

- Penalties include:
  - Corrective Action Plans
  - Intermediate Sanctions and Civil Monetary Penalties
    - Suspension of enrollment
    - Suspension of marketing
    - Suspension of payment
    - Civil Monetary Penalties (up to $25,000 per occurrence)
  - Contract termination
First Tier, Downstream & Related Entities

- **First Tier:** any party that enters into a written arrangement, acceptable to CMS, with an MA organization to provide administrative or health care services for a Medicare-eligible individual under the MA program
  - Examples: physicians, contracted hospitals, clinics, allied health providers, pharmacy benefit managers, claims processing, enrollment,

- **Downstream entity:** any party that enters into a written arrangement, acceptable to CMS, below the level of the arrangement between a MA organization and a first tier entity. These agreements continue downstream to the ultimate provider of both health and administrative services — must relate to core functions under CMS contract
  - Examples: mail order pharmacies, agents, brokers, marketing firms, call centers,

- **Related entity:** any entity that is related to the MA organization by common ownership or control and
  - 1) performs some of the sponsor’s management functions under contract or delegation;
  - 2) furnishes services to Medicare enrollees under an oral or written agreement; or
  - 3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.
  - Examples: wholly owned plan pharmacy benefit manager
Contract between CMS and MA Organization

- Regardless of delegation to others, MA organization retains ultimate responsibility for compliance to CMS
- Requirements for every entity in the delivery stream flow down from this contract (services must be “consistent and comply with” MA organization’s contractual obligations)
- Required provisions at 42 CFR §422.504
“MA plans are accountable for the performance of related entities, subcontractors and first-tier and downstream entities…MA organizations that delegate responsibilities under their contracts with CMS must include in their contracts with those entities provisions specifying that the entities must comply with all applicable Medicare laws, regulations, and CMS instructions. We will determine the extent to which MA plans oversee and monitor their contractors’ compliance with 42 CFR 422.504 and examine the processes that they use to ensure that contractors fulfill their contractual obligations.”
Contract between Plan and Provider

- Safeguard privacy and confidentiality and assure accuracy of beneficiary health records
- Specify prompt payment requirements between the parties
- Prohibition against provider holding MA enrollees responsible for payment of fees that are the legal obligation of the MA Plan to fulfill; covers insolvency of Plan, contract breach and provider billing
Accountability provisions:

– Compliance with Medicare laws, regulations and CMS instructions
– Agree to audits and inspections by CMS of any records or documentation related to MA plan
– Cooperate, assist and provide information as requested and maintain records for 10+ years
– If provider does credentialing, then right of MA plan to audit and approve, suspend or terminate contract
Fraud, Waste and Abuse Training

- As of January 1, 2009, MA plans must apply fraud, waste and abuse training to **all** contracted entities (first tier, downstream and related entities), not just direct employees of the MA plans.
- In August 2009, CMS clarified that the MA plan may either provide the training OR provide appropriate training materials.

“Due to the potential burden on downstream entities, CMS strongly encourages MAO and PDP sponsors to work together to provide standardized training.”

Letter entitled “Fraud, Waste and Abuse (FWA) Training Clarification, to MAO and PDP from K. Brandt, Director, Program Integrity Group, CMS, August 21, 2009.”
Topics to be Covered

• Laws and regulations related to MA fraud, waste and abuse (FWA)
• Obligations of contracted entities to have appropriate policies and procedures to address FWA
• Process for reporting to MA plan suspected FWA in contracted entities
• Protections for employees of contracted entities who report suspected FWA
• Types of FWA that can occur in contracted entities
Recently CMS *proposed* revising the requirements to recognize that first tier, downstream and related entities who have met the FWA certification requirements through enrollment into the Medicare program are *deemed* to have met the training and educational requirements FWA.

(For Part D, meeting the requirements for DMEPOS supplier is deemed to have met the FWA training.)
The Health Reform Law expanded RACs to MA plans and Medicaid claims; required by statute to be in place by December 31, 2010

RACs conduct post-payment reviews to detect and correct improper payments
Managed Medicaid

- States can contract with one or more entities (generally health plan) to perform patient enrollment, care management and claims adjudication

- Generally the states retain financing, determination of eligibility criteria and core benefit plan design

- Hospitals will contract with the health plan

- State specific regulations and provisions

Managed Medicaid

- Any entity that receives at least $5M annually in Medicaid payments must have written policies for all employees, contractors or agents, providing detailed information about false claims, false statements and whistleblower protections under the False Claims Act.

- In addition to RACs, CMS employs Medicaid Integrity Contractors (MICs) to perform post-payment audits of Medicaid claims and identify overpayments.

- The Health Reform Law increases federal funding for MICs starting in 2011.

- States stepping up review as well.
For compliance, how MA differs from Medicare Fee-For-Service?

- Contractual requirements regarding downstream entities (lithotripsy, mobile diagnostics, contracted physicians)
- Responsibilities for fraud, waste and abuse training for downstream providers and vendors
- Different relationship with the health plan; health plan may be differently motivated, more scrutiny
- Ultimate compliance accountability on health plan (so breach of contract with health plan is risk); however increased audit requirements
Questions?