CMS Role in the Managed Care Landscape

A Brief Overview

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CMS Involvement in Managed Care

- The Health Care Marketplace – ACA
- Medicare Advantage
- Medicare Accountable Care Organizations
- Medicaid Managed Care
- Medicare-Medicaid Plans (MMP)
CMS’ Role in ACA

- The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many reforms of the Affordable Care Act.
- The Regional Offices provide support in terms of providing an Account Manager for Qualified Health Plans and providing guidance for casework processing.

What Changed on January 1, 2014?

- Discrimination due to pre-existing conditions or gender is generally prohibited.
- Annual limits on insurance coverage of essential health benefits were eliminated for most plans.
- Advance payments of the premium tax credit are available.
- The Small Business Health Care Tax Credit increases.
- More people are eligible for Medicaid (in some states).
- Coverage through the Health Insurance Marketplace began.
Report on Affordability, Competition and Choice

- Consumers saved nearly $1.2 billion on their premiums
- Nearly 7 in 10 are paying $100 a month or less for coverage
- The average monthly premium dropped from $346 before tax credits to $82 after tax credits across all plans
  - An average of $69 per month after tax credits for silver plans (the most popular plan type) with a choice of 5 health insurers and 47 plans
- 266 insurers in the Marketplace by state, offering over 19,000 Marketplace plans across all rating areas
- Insurance companies must spend at least 80 cents of each premium dollar on health care, improvements to care, or provide a refund

What Is the Health Insurance Marketplace?

- Part of the Affordable Care Act
- Where qualified individuals and families directly compare private health insurance options
  - Known as qualified health plans (QHPs)
  - Can directly compare on the basis of price, benefits, quality, and other factors
- Also known as Exchanges
- Small Business Health Options Program (SHOP)
  - Marketplace for small employers
  - Provides coverage for their employees
CMS’ Role in ACA

- Essential health benefits include at least these 10 categories
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care (pediatric oral services may be provided by stand-alone plan)

How Qualified Health Plans Can Vary

- Some plans may cover additional benefits
- You may have to see certain providers or use certain hospitals (networks)
- The premiums, copayments, and coinsurance are different
- Quality of care data will be available
- The coverage level can vary within each plan
- Some special types of plans are structured differently
  - Like high-deductible (catastrophic) plans
Health Plan Categories

Lowest Premiums
Highest Out-of-Pocket Costs

Highest Premiums
Lowest Out-of-Pocket Costs

Covered Percent of Total Cost of Care Covered

60% 70% 80% 90%

Eligibility in the Individual Marketplace

• Marketplace eligibility requires you to
  – Live in its state or service area, and
  – Be a U.S. citizen or national, or
  – Be a non-citizen who is lawfully present in the U.S. for the entire period for which enrollment is sought
  – Not be incarcerated
    • Can apply for Marketplace coverage if pending disposition of charge
    • Can apply for Medicaid/CHIP at any time
The premium tax credit may be taken as advance payments to lower monthly premium costs, or as a refundable credit on the tax return you file.

Eligibility is based on:
- Household income and family size
  - Household income between 100% to 400% FPL
    - $23,550 – $94,200 for a family of 4 in 2013
    - $23,850 – $95,400 for a family of four in 2014
- Obtaining health insurance through the Marketplace
- Ineligibility for government-sponsored coverage, affordable employer-sponsored insurance, or certain other minimum essential coverage

Ways to Use a Premium Tax Credit

Choose to Get It Now:
Advance Payments of the Premium Tax Credit
- All or some of the premium tax credit is paid directly to your plan on a monthly basis
- You pay the difference between the monthly premium and advance payment
- You reconcile when you file your tax return for the coverage year*

Choose to Get It Later
- Don’t request any advance payments
- You pay the entire monthly plan premium
- Claim the full amount on the tax return you file for the coverage year

*You should report all changes in the information you provided on your application to avoid owing money after reconciliation on your tax return.
### Who is Eligible for Cost-Sharing Reductions?

- Lower costs on deductibles, copayments, and coinsurance
- To be eligible, you must
  - Have income at or below 250% FPL
    - $59,625 annually for a family of 4 in 2014
  - Receive the premium tax credit
  - Enroll in a Marketplace Silver-level plan
- Members of federally recognized Indian tribes
  - Don’t have to pay cost-sharing if household income is at or below 300% of the federal poverty level (FPL)
    - Up to around $71,550 for a family of 4 ($89,460 in Alaska) in 2014

### 1. What is Minimum Essential Coverage?

- If you have coverage from any of the following, you’re covered and **don’t have to do anything**
  - Employer-sponsored coverage, including COBRA and retiree
  - Individual coverage (outside the Marketplace)
  - Marketplace coverage
  - Medicare (Part A) and Medicare Advantage Plans
  - Most Medicaid coverage
  - Children’s Health Insurance Program (CHIP)
  - Certain Veterans health coverage (from the VA)

About 85% of Americans already have minimum essential coverage.
What Is a Medicare Advantage Plan?

• Health plan options
  – Approved by Medicare
  – Run by private companies
• Part of the Medicare program
• Sometimes called Part C
• Available across the country
• Provide Medicare-covered benefits
  – May cover extra benefits

Types of Medicare Advantage Plans

• Health Maintenance Organization (HMO)
• HMO Point-of-Service
• Preferred Provider Organization
• Special Needs Plan
• Private Fee-for-Service
• Medicare Medical Savings Account
Medicare Advantage (MA) Plan Network Changes

• Many types of MA plans have provider networks

• Plans may change networks at any time
  – Must protect beneficiaries from interruptions in medical care
  – Must maintain adequate access to services
  – Must notify beneficiaries who see affected providers
    • At least 30 days prior to termination

• Mid-year network changes aren’t a basis for a Special Enrollment Period

Medicare Advantage Financial Information

• Information on Medicare Advantage Rates & Statistics
  – http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/index.html
  • Payment ratebooks
  • Rate calculation data
  • Fee-for-service actuarial equivalent cost sharing factors
  • Benchmarks
  • Risk adjustment
  • Prescription drug plan base beneficiary premium
Medicare Advantage Financial Reporting

• Fiscal Soundness Reporting Requirements (FSRR)
  – FSRR Reporting Requirements - updated annually in March
  – Must submit to CMS - independently audited financial statements by April 30th as required under 42 CFR 422.516(a)(5)
    • Applies to
      – Medicare Advantage (MA) organizations,
      – Section 1876 cost contract plans,
      – Programs of All Inclusive Care for the Elderly (PACE)
      – Part D plan sponsors

Accountable Care Organizations

• An ACO promotes seamless coordinated care
  – Puts the beneficiary and family at the center
  – Remembers patients over time and place
  – Attends carefully to care transitions
  – Manages resources carefully and respectfully
  – Proactively manages the beneficiary’s care
  – Evaluates data to improve care and patient outcomes
  – Innovates around better health, better care and lower growth in costs through improvement
  – Invests in team-based care and workforce
Requirements to Become an ACO

- Accountable for the quality, cost and overall care of its Medicare fee-for-service beneficiaries
- Sign 3-year contract
- Have a formal legal structure to allow for shared savings distributions
- Have a minimum of 5,000 Medicare beneficiary lives assigned to its primary care doctors
- Have a leadership and management structure, including clinical and administrative systems
- Have defined processes to:
  - a. Promote evidence-based medicine and patient engagement
  - b. Report on quality and cost measures
  - c. Coordinate care, such as through the use of telehealth, remote patient monitoring, and other technologies
- Demonstrate they meet patient-centeredness criteria, such as the use of patient and caregiver assessments or the use of individualized care plans

Requirements and Costs to Become an ACO

- **Application Process**
  - Medicare has a formal and lengthy application process. A typical application is 350 – 400 pages, and Medicare meticulously reviews each in a three-step process before licenses are provided.

- **Quality Metrics**
  - Report on five (5) quality measures which are: patient/caregiver experience, care coordination, patient safety, preventative health, and at-risk population/frail elderly health.

- **Costs Involved**
  - It is estimated the average cost to form an ACO is between $1.8 to $4 million dollars per ACO per year. This is due to the amount of labor involved as well as legal fees and IT costs for the data extraction process and population health management systems needed.
How are ACOs Paid?

- In Medicare’s traditional fee-for-service payment system, doctors and hospitals generally are paid for each test and procedure.
- ACOs create an incentive to be more efficient by offering bonuses when providers keep costs down.
- Doctors and hospitals have to meet specific quality benchmarks, focusing on prevention and carefully managing patients with chronic diseases.
- In other words, providers get paid more for keeping their patients healthy and out of the hospital.

Medicare-Medicaid Plans (MMP)

- The Medicare-Medicaid Financial Alignment Initiative
  - designed to test innovative models to better align Medicare and Medicaid financing and the services provided to Medicare-Medicaid enrollees.
- An MMP is
  - a managed care plan that has entered into a three-way contract with CMS and the state in which the plan will operate.
- CMS.gov contains the following overview:
Medicare-Medicaid Plans (MMP)

- Medicare Statutory Requirements
- Social Security Act:
  - Section 1852(c) – Medicare Advantage Disclosure Requirements
  - Section 1860D-4 -Part D Dissemination of Information Requirements
  - Section 1851(h) -Approval of Marketing Material and Application Forms
  - Section 1851(j) -Marketing Prohibitions and Limitations

Medicaid Managed Care & Children’s Health Insurance Program

- States use statutory waiver flexibility to establish Medicaid Managed Care programs
  - Section 1915(b) Waiver – Freedom of Choice
  - Section 1115(b) Waiver – Can waive other requirements beyond participant Freedom of Choice
- Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009