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Providers should do annual check-ups on Medicare Advantage risk-sharing contracts

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A Medicare Advantage (MA) shared-savings/shared-risk arrangement (referred to as "shared-risk arrangement" in this article) is typically negotiated between a Medicare Advantage organization (MAO) and a provider before the final details of the contract year are known, particularly when the negotiated risk arrangement applies over multiple contract years.

An MAO submits a "bid" to the Centers for Medicare and Medicaid Services (CMS) in the summer prior to the contract year. For example, bids for the 2017 contract year were submitted to CMS in the summer of 2016. The bid development process is complex, but in short, it determines how much CMS will pay the MAO for providing benefits. CMS sets key data elements and "rules" for the bid development process as part of its rate announcement in the April prior to the bid submission. Meanwhile, MAOs are often in the midst of negotiating MA risk-sharing arrangements before the bids are final when there are still several "unknowns" outstanding. Some of these "unknowns" can have a material impact on the reasonableness of the final negotiated contract terms. Thus, it is imperative that providers review their MA shared-risk arrangements annually, particularly shared-risk arrangements set up to span multiple years.

Medical loss ratio targets are common

Many providers enter into shared-risk arrangements with MAOs. The most common method used in MA shared-risk arrangements is a medical loss ratio (MLR) target, i.e., claims divided by revenue. This type of arrangement is often referred to as a "Percentage of Premium." Revenue includes both member premium and CMS revenue. This approach is often used for MA risk deals because it aligns the carrier's and provider's incentives, particularly the incentive to ensure accurate coding. An MAO's revenue from CMS is directly tied to its risk score; that is, if an MAO's risk score improves, then its revenue increases. All else equal, as revenue improves, the medical loss ratio also improves. Thus, MA coding improvement creates a win-win situation for both plan and provider in MLR target arrangements.

MA revenue background

Revenue for MAOs from CMS is impacted by the following components:

1. County-specific fee-for-service (FFS) cost
2. County quartile
3. Bonus payment level based on the MAO's star rating
4. Double bonus county revenue "bump" for select counties
5. Risk score

CMS sets a benchmark revenue for each county based on underlying FFS cost. Each county is assigned to a quartile. A county's benchmark payment rate is adjusted based on its quartile assignment. The adjustments are as follows (from the highest-cost quartile to the lowest-cost quartile):

- 95%
- 100%
- 107.5%
- 115%

The benchmark revenue is increased 5% for MAOs with at least a 4-star rating. (New plans receive a 3.5% increase; an MAO does not receive a star rating until after three years and at least 500 members are enrolled in the MAO.)

Bonuses are doubled for MAOs in counties with the following characteristics:

1. Lower-than-average Medicare FFS costs
2. MA penetration rate of at least 25% as of December 2009
3. A designated urban floor benchmark

Finally, the benchmark revenue is adjusted by the MA coding penalty applied to all MAOs (to reflect that coding is inherently better in MA than FFS) and the MAO's actual risk.

Significant revenue components are outside the control of MAOs

Cost targets based on revenue introduce additional considerations because there are a number of factors that affect the revenue an MAO will receive from CMS. Many of these factors are beyond the control of both the MAO and the provider because they are set by CMS. Changes in these "external" factors will directly affect the MLR and significant changes in these factors from one year to the next could inadvertently make the target MLR stated in the shared risk arrangement inconsistent with the parties' goals.

Figure 1 includes key factors set by CMS that influence an MAO's revenue.

FIGURE 1: MAO REVENUE KEY FACTORS

Key factor
County-specific Medicare fee-for-service (FFS) costs
County's quartile assignment
Double bonus county assignment
Star rating of the MAO
Changes to Hierarchical Condition Categories (HCC) risk model
Changes to risk score methodology
MA coding adjustment "penalty"

CMS revenue adjustments are not the only considerations

Providers should also review items set at the MAO's discretion that could affect financial results. Some examples include:

- Final benefit package
  - Cost sharing
  - Additional (non-Medicare-covered) benefits
- Final premium
  - Need to ensure any increase in a plan's benefit richness is offset with an increase in member premium or CMS revenue
- Competitive position
- Administrative expense and profit margin assumptions included in the bid
- Benefit plans offered (if the shared-risk arrangement allows the MAO to add or remove the plans covered under the contract)
- Service area changes (if the shared-risk arrangement allows the MAO to revise its service area)
- Part D (i.e., pharmacy) risk if it is included in the arrangement
- Allocation of the medical and Part D revenues in the risk arrangement (if applicable)
- The MAOs' underwriting approach for employer group waiver plans, if included in the shared-risk agreement
- Any aggressive assumptions that could ultimately affect a final settlement (e.g., risk score coding improvement, anticipated utilization management reductions directly resulting from the implementation of the shared risk arrangement, etc.)

Annual check-ups are critical

Changes to any of the above factors from one year to the next can directly affect an MAO's revenue and/or cost. Significant changes can and do occur. Annual check-ups are critical in multi-year MA shared-risk arrangements with an MLR target because CMS changes and the MAO's bid assumptions may lead to a reduction in revenue without an offsetting reduction to cost. A plan's reaction to any revenue change, by either changing benefits or member premiums, ultimately determines whether or not the existing proposed MLR target remains reasonable.

MA risk scores

In 2017, CMS will calculate an MAO's risk score based on a blend of Risk Adjustment Processing System (RAPS) files and encounter data submissions. CMS plans to base risk scores solely on encounter data by 2020. An MAO may see a drop in risk scores if it doesn't submit robust encounter data. This change and other changes to the risk score methodology and model can affect an MAO's risk score (and thus its revenue).

Further, CMS assumes MAOs code better than Medicare FFS, so CMS applies a coding adjustment that reduces an MAO's risk score. The adjustment is a 5.66% reduction in risk scores in 2017.

For additional information on MA risk scores, please refer to http://us.milliman.com/uploadedFiles/insight/2016/2308HDP_Medicare-EDS.pdf.

CMS releases MA plan information in the fall for the upcoming calendar year. We recommend an annual "check-up" of contractual terms after CMS releases the plan information. Specifically, we recommend providers in an MA shared-risk arrangement with an MAO carefully review key contract provisions (e.g., the MLR target) and consider adjustments to the contract terms if needed. It is also a good idea to engage with that MAO during the development of its MA bids each spring to understand any potential material benefit and premium changes.

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