Volume 16, Number 15 August 19, 2010

Medicare Advantage News

News and Analysis of Medicare Advantage, Medicare Part D and Managed Medicaid

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CMS Boosts Scrutiny of MA Plans' Quality Programs, Initially Expands Data Reporting

CMS seems to be ramping up its scrutiny of hitherto neglected Medicare Advantage plans' Quality Improvement Projects (QIPs) and Chronic Care Improvement Programs (CCIPs), based on several recent developments. And the likelihood of much more oversight over what has been pretty much left up to the MA plans in recent years is doubly significant in light of the growing importance quality measures will have in determining future payment rates for the plans.

Moreover, new CMS Administrator Donald Berwick, M.D., has made quality initiatives a big focus of his work before coming to the agency and is likely to continue that now. Plans therefore could be at risk of having their mandatory QIPs and CCIPs rejected by CMS, with consequences for the agency's star ratings that will determine quality bonuses for MA plans beginning in 2012 *(MAN 7/1/10, p. 1)*. One MA consultant tells *MAN* that while he hasn't heard of any such rejections so far, he does expect the agency "to get tougher" in oversight of the programs.

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Utilization Drops Aid MA Plans' Quarterly Earnings, Help Lower Medical Loss Ratios

Cost controls were at the heart of Medicare Advantage plan operators' earnings gains in the second quarter and were prime items for discussion in the most recent batch of their conference calls on the financial results. In particular, MA medical services utilization continued to moderate, medical loss ratios largely as a result fell substantially for many firms, and plans reported new moves to cut their future costs.

The favorable cost trends, coupled with continuing MA membership growth, allowed many of the plans to boost their earnings guidance for full-year 2010. But they also stressed that because of problems on the horizon, including declining MA payment rates and minimum MLR requirements, continuing tight cost control is a priority.

Humana Inc., in its earnings report and conference call with investors Aug. 2, emphasized several aspects of the cost issues. Chief Operating Officer Jim Murray, in response to a question on the earnings call, said the company is seeing a slowdown in utilization across its book of business, albeit less in the Medicare sector than in the commercial one. That's partly because Medicare is less tied to economic cycles, added President and CEO Michael McCallister.

Murray noted that Humana is likely to cut commissions to brokers, as some of its competitors have said they would do. He also said the company can cut other administrative expenses considerably, with one objective of both moves to help the company comply with minimum MLRs under the new health reform law *(MAN 4/15/10, p. 1)*. Humana's MA MLR in the second quarter was about 83.9%, estimated securities analyst Christine Arnold of Cowen & Co., up from 82.4% in the year-ago period (see table, p. 3) but below the 85% minimum that will be needed for MA plans starting in 2014. And the selling,

Published by Atlantic Information Services, Inc., Washington, DC • 800-521-4323 • www.AISHealth.com
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general and administrative (SG&A) cost percentage for the Humana MA sector declined in the most recent quarter because of both economies of scale and cuts in administrative expenses.

MA premium revenue, the company said, climbed to $4.89 billion from $4.15 billion in the year-ago period, and MA membership reached 1.76 million on June 30, up from 1.50 million one year earlier.

Securities analyst Carl McDonald of Citigroup Investment Research, in an Aug. 2 research note, forecast Humana's MA enrollment will grow for 2011. This is despite the fact that 480,000 enrollees are now in private-fee-for-service plans that will end in most counties Dec. 31 with expiration of network "deeming" for PFFS in non-rural areas. Company executives said the vast majority of these enrollees will have network options to transition into. Specifically, only 25,000 will have no network option and therefore will leave the company's MA products, and just another 65,000 will have to make an actual disenrollment-enrollment decision to switch to a local PPO in order to stay with Humana. Another 50,000 are in counties considered rural and therefore allowed to keep deemed PFFS.

HealthSpring Inc., in its quarterly earnings report July 29, reported similar favorable cost-related developments and posted an MA MLR of 77.9% that was well below the year-ago period's 82.0%. The company's full-year 2010 forecast is 79%. The low figure in relation to the minimum MA MLR that will be required did not worry McDonald, who said the firm has more ability than do other plans to shift SG&A costs to medical expense "because of its close relationship with many of its contracted providers."

While other factors such as benefit-design changes and premium-revenue increases contributed to the large MLR drop, the biggest factor was a utilization drop "that should last for the rest of the year," albeit at a reduced rate of decline, said Chairman and CEO Herb Fritch. Like several other MA plan CEOs in earnings calls, he said "it's hard to pinpoint" the reasons for the utilization drop, but suggested it seems to be "more industrywide" than specific to HealthSpring.

The company said that MA premium revenue jumped 9.9% to $640.8 million in the 2010 quarter versus the year-ago period, while MA membership climbed to 197,436 on June 30 from 182,231 one year earlier.

Fritch expressed optimism about the not-yet-known results of its MA product bids for 2011, saying the company was able to maintain and, in some cases, improve the benefits it offers members, although he conceded that some changes made "could erode [profit] margins."

Universal Gets New Markets Approved

Universal American Corp., which like HealthSpring is mainly focused on MA, has been notified by CMS of 12 new markets approved for 2011, said Chairman and CEO Richard Barasch in the company's July 29 earnings call. He did not disclose those markets.

The company posted big increases in MA operating income and said MA revenue advanced to $796.3 million in the second quarter from $661.2 million in the second period of 2009. MA membership rose to 295,000 on June 30 from 280,000 a year before.

Universal American said its MA MLR for the second quarter was 82.6%, down from a year ago, but predicted the rate is likely to go up in the second half to wind up at 83.0% to 85.0% for the full year.

The insurer has the bulk (202,000 as of June 30) of its membership in PFFS plans, leaving it relatively vulnerable to the end of PFFS deeming. But based on current classifications, Universal American said, 24% of its PFFS membership is in rural counties that can stay PFFS in 2011. Moreover, its membership in network-based plans jumped 48% to 93,000 from the year-ago period, driven by growth in PPOs, the company said. However, McDonald forecast that Universal nevertheless will lose almost 70,000 PFFS members next year.

Coventry Health Care, Inc. terminated its PFFS product at the end of the last year — "probably too early," according to McDonald, but it was able to boost

Medicare Advantage News (ISSN: 1089-6589) is published 24 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 202-775-9008, www.AISHealth.com.

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membership in MA coordinated care plans to 192,000 on June 30, up 10,000 from the year-ago period, the company reported July 30. The MA MLR plummeted to 81.4% from a 90.4% rate in the year-ago period that reflects the generally higher MLRs of PFFS plans, and Chairman and CEO Allen Wise forecast in the earnings call that the full-year MLR will wind up in the "mid-80s."

He, like most of the health plan CEOs reporting second-quarter results, cited utilization declines as a factor in improving results. Asked during the earnings call why utilization is down, Wise replied, "We don't know," although he cited the weak economy as a possible factor.

The firm's longstanding cost-control focus played a role in Coventry's recent deal to acquire MA operator MHP, Inc. and its subsidiary Mercy Health Plans from Sisters of Mercy Health System *(MAN 7/1/10, p. 8)* and illustrates Coventry's preference to partner with provider-owned entities that "can give us a predictable cost structure," Wise said during the earnings call.

The story of declining cost trends was not uniform through the industry, though. ***Health Net, Inc.***, in reporting quarterly results Aug. 3, posted an MA MLR of 88.5% for the second quarter, up from 85.6% in the year-ago period but "in line with expectations," according to President and CEO Jay Gellert. "We believe we're on track to end the year at around 88%, and that's a reasonable ratio given the high percentage of capitation in our western MA markets," he said in the earnings call. He explained that in capitated contracts with providers, Health Net tends to get the benefits from declining utilization later — when those contracts are next renegotiated.

"I think we have an opportunity to improve our MLR in the cases that it's above the [required] floors," Gellert said. 'That's a focus of our activities next year."

Medicare Advantage Plans' MA Medical Loss Ratios, Membership for 2Q10

Company	MLR 2Q10	MLR 2Q09	Membership 6/30/10	Membership 6/30/09
Aetna	86.4%	89.4%	451,000	423,000
CIGNA	NA	NA	147,000	49,000
Coventry	81.2%	90.4%	192,000	182,000
Health Net	88.5%	85.6%	132,000	134,000
HealthSpring	77.9%	82.0%	197,436	182,231
Humana	83.9%	82.4%	1,761,100	1,499,800
Triple-S	79.9%	83.2%	55,625	61,057
UnitedHealth	82.2%	82.8%	2,040,000	1,740,000
Universal Amer.	82.6%	84.3%	295,000	238,400
WellPoint	NA	NA	480,000	435,000

NA=Not available.

SOURCES: Compiled by *MAN* from company reports and estimates from Citigroup Investment Research and Cowen & Co., August 2010

But the fact that the company's MA and consolidated MLRs are well above the minimums that will be required actually could be a blessing, securities analysts pointed out. "Minimum medical loss ratios really aren't much of a concern for Health Net now," said McDonald, for instance, in an Aug. 3 research note. The firm doesn't have the distraction of trying to lower its MLR now, it was able to re-establish high reserve levels without concern for consequences, and its outlook is clearer than those of many competitors, he suggested.

Contact McDonald at (617) 247-6312 and Arnold at (646) 562-1322. ✧

Medicaid Plans Had Good Quarter, But Still Fear Pay-Rate Outlook

With a couple of exceptions due to unique factors, Medicaid managed care companies had a good second quarter, based on financial reports released in late July and early August. But they are cautious about the short-term outlook, especially in light of state financial pressures on plan payment rates.

Even there, though, the outlook may be improved. ***Centene Corp.***, for instance, forecast a 1% to 3% overall rise in Medicaid pay rates this year, compared with just a 0.1% rise in the first half of 2010 and up from its previous forecast of zero to 2%. In an earnings conference call with investors July 27, Chairman and CEO Michael Neidorff cited "fresh evidence" of "rational decisions" by states for the upward revision. That includes a rate hike effective July 1 in Georgia and ones expected Sept. 1 in Florida and Texas, noted securities analyst Carl McDonald of Citigroup Investment Research.

Centene posted net income for the second quarter of $22.78 million or 46 cents a share, compared with $20.23 million or 47 cents a share in the year-ago period, when there were fewer shares outstanding. Revenues climbed 12.8% to $1.05 billion, aided by membership growth in each of its states, said Chief Financial Officer William Schaffel in the earnings call. Medicaid membership on June 30 was 1,135,500, up from 958,600 one year earlier.

The company reported a medical loss ratio of 83.8% for the most recent quarter, up from 83.1% in the 2009 period primarily because of new markets for which it is anticipating higher rates than in existing markets, Schaffel said. Centene projected a full-year MLR of 83.5% to 84.5%.

AMERIGROUP Corp. handily beat analyst expectations by reporting second-quarter net income of $67.2 million or $1.31 a share, up from $49.6 million or 94 cents a share in the year-ago period. Total revenues jumped 11.3% to $1.4 billion. The company posted an MLR of 82.3% in the most recent period, far below the 85.9% in the year-ago quarter. The drop stemmed primarily from a continued

slowdown in medical cost trends, was "better than expected" and included some moderation on the inpatient side, Chairman and CEO James Carlson said in the July 30 earnings call. Membership as of June 30 was 1,904,000, up from 1,723,000 one year earlier, according to AMERIGROUP.

Carlson said that state finances still are very tight, but he forecast overall Medicaid plan rate hikes for AMERIGROUP this year at about 3%. Specifically, he said, New Jersey raised rates 4.6%, Maryland's 0.25% rate hike in July translates to a full-year hike of about 4.7%, Texas rates will go up 4.2% effective Sept. 1, and Virginia boosted rates more than 3% and instituted mandatory provider reimbursement cuts. He added that Georgia's rate hike is not yet finalized but is expected to be about 1.8%, and Florida still is considering its new rates effective Sept. 1.

Citigroup's McDonald said the company's commentary in late July made it sound like "the rate environment was actually a bit better than previously expected, despite all the state budget difficulties."

Unusual Factors Hamper Molina Results

The picture was a little different at ***Molina Healthcare, Inc.,*** where earnings were down because of unusual factors but still easily beat expectations. Specifically, Molina posted second-period net income of $10.58 million or 41 cents a share, down from $14.57 million or 56 cents a share in the 2009 period. Premium revenues advanced to $976.69 million from $925.51 million, as membership grew to 1,498,000 on June 30 from 1,368,000 one year earlier, the company said. The MLR was 86% in the most recent period, down from 86.8% in the year-ago period.

CEO J. Mario Molina, M.D., in the Aug. 4 earnings call, called it a "good" quarter and noted that Molina's medical utilization trends are flatter than what some other Medicaid firms have been reporting, partly as a result of the states it serves. Since it announced a 4 million share secondary stock offering the same day, the company said it was precluded from making forecasts now, but the CEO did say the firm expects rate increases the rest of this year to be in the "low single digits."

One factor hampering Molina's second-quarter performance, pointed out CFO John Molina, was a retroactive premium cut by Michigan that reduced earnings by 12 cents a share. Premium rates also dropped in Ohio and Missouri as a result of the company transferring pharmacy risk back to those states. On the plus side going forward, he said, Washington state granted a 2.5% pay increase effective July 1.

WellCare Health Plans, Inc., which also has large Medicare Advantage operations, posted on Aug. 9 a second-quarter net loss of $128.9 million or $3.05 a share, largely because of charges related to legal settlements, compared with net income of $37.0 million or 88 cents a share in the year-ago period. Premium revenues plunged to $1.34 billion from $1.79 billion, mainly as a result of its pullout from MA private-fee-for-service products at the end of last year coupled with the impact of CMS marketing and enrollment sanctions on its Medicare plans.

Medicaid membership, however, also dropped, to 800,698 on June 30 from 813,759 one year earlier. CEO Alec Cunningham, in the earnings call, attributed that largely to its decision to pull out of certain Florida counties. While the Medicaid rate environment "continues to be challenging," Cunningham said, he doesn't anticipate any rate cuts the remainder of this year and said the Georgia rate hike appears to be in the 1.5% to 2% range.

For the second quarter, the firm reported a Medicaid MLR of 86.0%, up from 85.0% in the year-ago period.

The company's major disclosure Aug. 9, however, involved an agreement on the "material terms" of a $200 million settlement to resolve claims in a class-action lawsuit related to state and federal fraud investigations under its former management.

Contact McDonald at carl.mcdonald@citi.com. ✧

UPMC Reports Getting Financial, Clinical Gains From Coding Effort

UPMC Health Plan has achieved both clinical and financial benefits from a large-scale Medicare risk-adjustment revenue-optimization program, a vice president of the plan told a conference session late last month. And the plan may expand upon the program to include some "gain sharing" with large provider groups in the future, John Lovelace, who is also president of its UPMC for Life Specialty Plan, a Medicare Advantage Special Needs Plan, tells *MAN* this month. He said the program so far has resulted in about a 3% ($30 million) boost in revenue and a 1.7% rise in risk scores.

The initiative grew out of certain characteristics the Pittsburgh-based plan observed regarding the approximately 18,000-member SNP, Lovelace told a session of the World Congress Annual Leadership Summit on Medicare in Washington, D.C. The majority of the membership in the plan, which is the nation's sixth largest SNP and has very little disenrollment, is under age 65, he said. That is an issue since the Hierarchical Condition Category (HCC) risk score — which CMS uses to help determine plan payments — for the under-65 component has been just about 1 (compared with 1.28 overall for UPMC's 85,000 MA lives), and probably should be higher in light of the characteristics of that population, Lovelace said.

Nearly 60% of the beneficiaries are disabled, about one-third of those under age 65 are severely mentally ill, and many members have multiple comorbid conditions

and are on multiple medications, he noted. Many of them live alone, he added. The net effect has been that UPMC for Life's revenue for these patients has been going down (partly because of the CMS coding-intensity adjustment for MA) while costs continue to rise, especially since most contracted providers are paid on a fee-for-service basis. That has led to the need for revenue optimization strategies, according to Lovelace.

Before 2009, he recalled, UPMC for Life had done only retrospective HCC coding reviews — which don't help the plan manage care — along with outreaches to members who didn't have a primary care physician visit by the third quarter of the calendar year. Starting in 2009, though, it changed the retrospective approach and instituted prospective efforts, and they now account for about 80% of its HCC optimization efforts, he said.

Lovelace reported that the initial efforts, which went through the members themselves, did not find as many medical conditions as expected. UPMC for Life decided therefore to look to the first diagnosing provider for conditions charted but not coded, an effort that is hard to do retrospectively, Lovelace pointed out. A key part, begun in 2010, of this strategy is to persuade providers to complete a comprehensive assessment for the top 25% of the SNP's population identified on the basis of risk potential. It disregards acute conditions such as fractures that are not expected to persist in determining the members whose records should be probed.

There also is, according to Lovelace, a separate initiative involving two large provider groups affiliated with the UPMC health system, plus institutional and home assessment programs conducted by an external vendor. In

Expanded RAC Audits Could Substantially Raise Costs for MA Plans

Enhanced civil monetary penalties (CMPs) combined with the extension of Medicare Recovery Audit Contractor audits could cost Medicare Advantage companies large amounts of money, even if the plans opt to settle rather than fight fraud charges, according to attorney Clifford Barnes, a partner in Epstein Becker & Green, P.C.

The Social Security Act authorizes CMPs for several activities, including failing to report and return overpayments, for which the offender can be fined $10,000 per item or service plus an assessment of up to three times the amount improperly claimed. The health reform law calls for an expansion of the RAC program by Dec. 31.

Because of the financial relationship between MA plans and the federal government, when an insurer is suspected of fraud, the firm is likely to do what it takes to avoid litigation, says Barnes, who represents providers and managed care companies.

"The Medicare managed care companies are not going to want to be in litigation with an agency of their customer," Barnes tells *MAN*, which is why settlements become the route of choice. .

Prosecutors will offer settlements of two times the amount, and the MA plans will have to take it, according to Barnes. "That means an allegation of fraud is likely to require managed care companies to pay huge sums of dollars," he adds.

"We have not seen a great deal of settlements [with MA plans], as most of the settlements are focused on providers," Barnes tells *MAN*. But "as a result of the RAC audits…we expect that the number of managed care companies that are subject to audits and then potentially…subject to enhanced CMPs" will rise.

The Obama administration hopes that money recovered through the RAC program and the Health Care Fraud Prevention and Enforcement Action Team will offset part of the cost of health reform. Current recovery efforts have saved only a limited amount of money, and therefore an expansion of the program will have a significant impact, Barnes says.

The estimates for Medicare fraud are upwards of $20 billion annually, according to Barnes. However, in 2009, only $2.51 billion was recovered.

As a result, the government is pushing RACs to recover additional funds. "These RAC audits have a specific focus for Medicare managed [care] plans," Barnes says *(MAN 7/15/10, p. 5)*.

"We don't know what the results are going to be, but the fact that they are launching RAC audits" is telling, he says. "At a minimum, managed care companies have to get ready for these audits…and redouble their efforts in making sure they have an antifraud plan."

While some MA plans are launching new efforts to prepare for the increase in RAC audits, including developing internal special investigations units, others are choosing to better utilize the services already offered by third-party companies, including additional auditing programs.

Contact Barnes at (202) 861-1856.

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addition, the SNP still itself conducts "outreach" to members without a PCP visit by the third quarter.

In its prospective approach, he explained, UPMC for Life looked at first-quarter data for the targeted beneficiaries to determine key diagnoses that were coded in the past but not present on current-year claims.

Lovelace suggested that items to resolve internally before pursuing HCC changes for a beneficiary include determining:

◆ What is the difference between the member's actual risk score and the best expected score based on historical data;

◆ Whether the member is new to the plan; and

◆ Whether he or she has been seen in the past six months by his or her PCP.

A key additional question, for an HCC category once present for the beneficiary but now missing, is what was the volume of claims submitted previously for that diagnosis? "The more previous claims, the more likely we are to chase it," Lovelace said.

On the provider side, he continued, the plan's strategy focuses on finding provider groups that have poor HCC scores associated with their beneficiary panels. The health plan, he said, uses "data analytics" to link members to PCPs and/or specialists. UPMC for Life develops reporting for providers that show "targeted diagnoses that need to be reviewed and coded." Mental health clinics, added Lovelace, frequently don't show a lot of HCC coding and thus are good targets for reviews.

It is better for members to hear from providers than from the health plan itself about care management, Lovelace asserted. Persuading providers to make such efforts, he said, requires strong working relationships with network providers, including with their support staff. Toward this end, UPMC for Life uses different kinds of incentives for different providers.

Lovelace cited as an example payments to providers ranging from $50 to $130 for completion of full medical assessments, with the larger amounts coming if medical claims match what is said in the assessment.

UPMC is "pleased with the success" of the initiative so far in relation to both revenue and clinical management, he tells *MAN*. Although it has not instituted gain sharing with providers based on the results in this initial stage, he says, it is exploring such gain sharing in the future with large provider groups.

Other potential changes to the initiative, according to Lovelace, include more in-home assessments of beneficiaries, and a more comprehensive framework for "blending" programs such as quality improvement and pay-for-performance with the HCC initiative. The latter effort probably will take place in 2011, he adds.

Contact Lovelace at (412) 454-5269 or lovelacejg@upmc.edu. ✧

Insurance Exchanges: How to Prepare for Their Impact on Small-Group and Individual Markets

- While exchanges have been established in states such as Massachusetts and Utah, the results have been mixed. What lessons have been learned?
- Guaranteed issue and a weak individual mandate could make participation unattractive to insurers. How will exchanges protect against adverse selection?
- Health plans that offer products will need to be more transparent than ever and get approval for rate increases. Will these restrictive rules limit participation?
- Health plans will be required to offer standardized products so that price quotes are comparable. What sorts of margins can insurers expect?
- Exchanges could make agents and brokers obsolete, or create new opportunities for brokers as "navigators." What is the future for brokers and agents?

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CCIPs, QIPs Will Get More Scrutiny

continued from p. 1

CMS late last month issued MA plans new reporting templates for both CCIP and QIP initiatives that supply much more detail than the 2007 versions, the most recent revisions of the forms. The new versions, available through CMS's Health Plan Management System (HPMS), are labeled as "pending approval" by the Office of Management and Budget, and their use is not required until OMB signs off on them. However, MA plans say they are treating these as final documents.

CMS declined to respond to *MAN*'s specific questions about the revisions and the apparent increase in scrutiny of CCIPs and QIPs. But it did supply a copy of a July 23 memo to MA plans from Danielle Moon, director of the agency's Medicare Drug & Health Plan Contract Administration Group, granting the plans an extension until Aug. 27 from the original July 30 deadline for submission of CCIPs and QIPs by MA organizations in existence on or before Jan. 1, 2009. That extension, said one MA industry executive who asked not to be identified, probably resulted from requests for more time to supply the detailed information requested, especially since the plans may not have been compiling it previously.

MA Plans Must Detail CCIP Methodology

The new reporting template for CCIPs, which have been mandatory since January 2006, requires plans to do such things as supply detailed descriptions of the methodology used for including MA enrollees, along with the number of members actually identified and participating, extensive details about the interventions and monitoring employed in the program, descriptions of the outcomes measures used and how improvements on them are achieved, in-depth information about any aspects of the CCIP that are delegated or outsourced, and specific details about any provider incentives related to the programs.

The QIP template is even more extensive, especially if plans use QI indicators other than ones in the HEDIS, Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Medicare Health Outcomes Survey (HOS) instruments. Plans must describe baseline data-collection methodology and any changes in it since program initiation, results of the program in detailed tabular format, specific interventions used and the barriers they address, and details about any delegated or outsourced aspects.

The MA executive says the objective of this year's forms may be to get baseline data that can be used in the future as a foundation for measuring plan performance on quality. If that's the case, he theorizes, the next iteration of the forms might be accompanied by guidance about the elements, including outcome measures, CMS wants in a quality-improvement program.

To understand the significance of the changed CMS oversight of both programs, says the executive, it is useful to look at the history of them. When managed Medicare was in its former Medicare+Choice incarnation, the programs were "big deals," he says, but that changed when M+C plans had extensive pullouts from the market in the late 1990s as a result of payment rates that the plans deemed inadequate. CMS then eased up on data-reporting requirements and other oversight of CCIPs and QIPs out of fear that they could lead to more pullouts.

With knowledge of that easing, some MA plans did not pay a great deal of attention to those programs, especially since there weren't any payments associated with them. Moreover, the regulatory environment surrounding the initiatives "has been pretty ambiguous," one industry observer says.

Although annual data reporting continued to be required, CMS never apparently audited the data on those programs after the pullout era. This April, though, the MA plan executive notes, CMS guidance *(MAN 4/29/10, p. 1)* included a whole section on the two programs in which the government reasserted its authority over them. The implication, he added, was that oversight of the programs eventually could affect the CMS star ratings needed to qualify for the new quality bonuses.

That could mark a big turnaround for the programs, which in recent years have used basically whatever outcomes measures the plans wanted.

Plans Have Had Flexibility on Programs

Plans have had the flexibility to establish the design of their CCIPs and QIPs, but they needed to submit annual reports on those initiatives, notes attorney Bruce Merlin Fried, a partner in Sonnenschein Nath & Rosenthal and the managed care head at HCFA during the Clinton administration. While there appears to be no specific language in laws on CMS rejecting those initiatives, he tells *MAN*, it is likely that the authority HHS has been granted, including under the reform law, would give CMS this power.

Any tightening of the scrutiny of CCIPs and QIPs, he suggests, should take place within the context of how the whole quality-improvement process will be designed going forward. That should include an overhaul of the CMS star-rating system, which is "widely recognized as deficient," partly because it uses outdated data and "dubious measures" (e.g., handling of appeals) for health care quality and because its current use by Medicare beneficiaries is "negligible," Fried asserts.

Fried says he hopes Berwick, who is a "leading thinker" on how to improve quality, will bring "leadership" to this subject. If any ramping up of CCIP and QIP scrutiny is going to occur without such expert guidance, then "it's a failed opportunity," according to Fried. CMS can't just be

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"turning up the screws" on MA plans via such means as CCIP scrutiny, he says, adding, "If anything calls for a partnership, it's this."

Stephen Wood, senior vice president at Ingenix Consulting, echoes some of those concerns, but also maintains that "perhaps it is a good thing that CMS will pay more attention to this." It is logical that oversight of CCIPs and QIPs would get tougher, says Wood, since Berwick emphasizes quality and since the star system that will determine MA plan payment bonuses starting in 2012 is tied to quality measures.

There have been discussions in some segments of the industry that it might be a good idea for plans to form a council that would present its own ideas for reforming CCIPs. They appear to think that the timing of any "ratcheting up" of regulation of those quality initiatives would be bad, the plan executive says, considering that MA payment rates will start going down in 2012 and already are rising much more slowly than are medical costs. Meanwhile, MA plans must spend more to meet new reporting requirements and curbs on their product bids, he contends.

If CMS boosts the requirements for CCIPs and QIPs, Wood says, "plans will either invest a lot of money in this, or it will be another nail in the coffin."

Contact Fried at (202) 408-9159 and Wood at (312) 429-3906. ✧

NEWS BRIEFS

◆ **The national average monthly bid amount for Medicare Part D plans in 2011 is $87.05, down from $88.33 in 2010, CMS announced Aug. 18.** The 2011 figure, which is a weighted average of standardized bid amounts for both stand-alone and Medicare Advantage prescription drug plans, indicates "very aggressive bidding," Stephen Wood, senior vice president at Ingenix Consulting, tells *MAN*. CMS also said that only 500,000 Part D low-income subsidy beneficiaries will need to move to new plans next year because their current plan bid too much above the LIS benchmark premium amount. That's down from 800,000 who had to switch plans this year and reflects CMS's decision to let plans bidding up to $2 over the LIS benchmark (up from $1 previously) keep LIS beneficiaries for 2011, Wood said. CMS also reported that the Part D base beneficiary premium for standard coverage in 2011 is $32.34, up from $31.94 in 2010, and that average premiums will be about $30 after beneficiaries switch to lower-cost plans. View the CMS 2011 Part D bid fact sheet at www.cms.gov/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2011.pdf. Contact Wood at (312) 429-3906.

◆ **On Aug. 10, Centene Corp.'s Florida subsidiary, Sunshine State Health Plan, said it inked a definitive agreement to acquire Citrus Health Care's Medicaid and long-term care (LTC) diversion assets.** Financial terms of the planned acquisition were not disclosed. Citrus, a subsidiary of PHC Holdings of Florida, Inc., serves 52,000 "nonreform" Medicaid members and 2,000 LTC members in the Tampa and Orlando areas. On April 12, PHC's parent company, WellMed Medical Management, Inc., acquired Citrus, which also has MA operations, for an undisclosed price *(MAN 4/29/10, p. 3)*. Centene said the planned transaction is consistent with Sunshine State's goal of growing its Medicaid market share in nonreform Florida counties through acquisitions in the state. According to the insurer, the acquisition of the LTC diversion unit also opens a new growth opportunity for it in Florida. Citrus' Medicaid and LTC diversion business are expected to add revenues of $120 million to $130 million on an annual basis, said Centene. Visit www.centene.com.

◆ **Rhode Island on Aug. 16 said it picked UnitedHealthcare of New England and Neighborhood Health Plan of Rhode Island to cover Medicaid enrollees.** The state received bids from only those two firms for the contract period, which begins Sept. 1. Blue Cross & Blue Shield of Rhode Island — which has participated in one of the programs for 16 years and now covers 15,000 members in the program — did not submit a proposal. In a prepared statement, BCBSRI spokeswoman Laura Calenda said the company is focused on "administering the new High Risk Pool and continuing to serve as the state's insurer-of-last-resort." Visit www.dhs.ri.gov.

◆ **The government of Puerto Rico on Aug. 16 informed Triple-S Management Corp., the largest managed care company in Puerto Rico, that its managed care subsidiary will not be invited to participate in the negotiation process for any new Medicaid plan awards under the program.** Securities analyst Carl McDonald of Citigroup Investment Research wrote in an Aug. 17 research note that Triple-S said the government's decision was based primarily on pricing. He added that the decision improves the chances of Aveta Inc. and Centene Corp. (in partnership with a local Puerto Rican plan) to obtain the pacts. Triple-S now is responsible for managing three of the eight Reform regions in Puerto Rico. Visit www.triplesmanagement.com.

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