Advising the Congress on Medicare issues

Medicare Advantage program: Status report

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MEDPAC

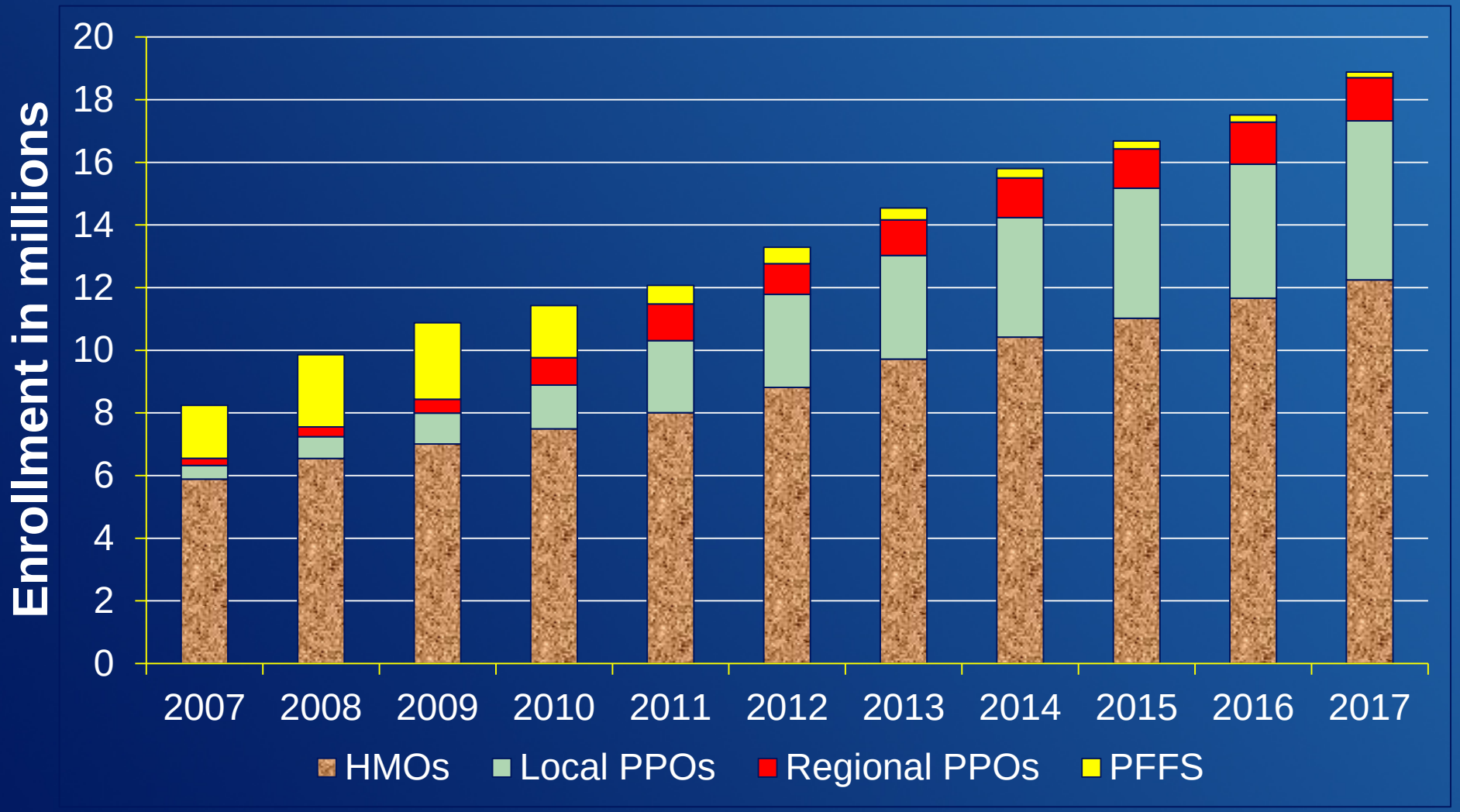
Today's presentation

- Status report on Medicare Advantage (MA) enrollment, availability, benchmarks, bids, and payment
- Update on coding intensity
- Chairman's draft recommendations on contract consolidation and quality reporting

MA plan payment policy

- Payments based on plan bids, benchmarks (county-based and risk-adjusted), and quality scores
- Benchmarks range from 115% of FFS in lowest-FFS counties to 95% of FFS in highest-spending counties
- Benchmarks are increased for plans with high quality scores
- If bid > benchmark, program pays benchmark, enrollee pays premium
- If bid < benchmark, plans get a percentage (varies by plan quality score) of the difference as a “rebate” for extra benefits, Medicare keeps the rest of the difference

MA enrollment by plan type, 2007-2017



Source: CMS enrollment data

Draft – subject to change

Percentage of Medicare beneficiaries with an MA plan available, 2014-2018

Type of plan	2014	2015	2016	2017	2018
Any MA	100%	99%	99%	99%	**99%**
HMO/ Local PPO	95	95	96	95	**96**
Regional PPO	71	70	73	74	**74**
PFFS	53	47	47	45	**41**
Avg. number of choices					
County weighted	10	9	9	10	**10**
Beneficiary weighted	18	17	18	18	**20**
Average rebate available for extra-benefits*	$75	$76	$81	$89	**$95**

*for non-employer, non-SNP plans

Note: PFFS (private fee-for-service), MA (Medicare Advantage)

Source: CMS website, landscape file, and plan bid submissions.

Draft – subject to change

Benchmarks, bids, and payments relative to FFS for 2018

	Benchmarks/ FFS	Bids/ FFS	Payments/ FFS*
All MA plans	107%	90%	101%
HMO	106	88	100
Local PPO	110	99	106
Regional PPO	102	94	98
PFFS	107	105	106
Restricted availability plans included in totals above			
SNP	106	93	101

Note: MA (Medicare Advantage), PFFS (private fee-for-service), SNP (Special Needs Plan). All numbers reflect quality bonuses, but not coding differences between MA and FFS Medicare.

* Payments would average 103 percent of FFS if coding intensity were to be reflected fully.

Source: MedPAC analysis of CMS bid and rate data.

MA risk adjustment

- Medicare pays MA plans a capitated rate
  - Rate = base $ amount
    x ***beneficiary-specific risk score***
- Risk scores adjust payment
  - Increase base rate for more costly beneficiaries
  - Decrease base rate for less costly beneficiaries
- Risk scores produced by CMS-HCC model
  - Includes demographic characteristics & HCCs (medical conditions) identified by diagnosis codes

MA and FFS diagnostic coding

- Less coding incentive in FFS Medicare
  - Payment for physician and outpatient services is not based on diagnosis codes
- Strong financial coding incentive in MA
  - Higher payment for more HCCs documented
  - Higher MA risk scores for equivalent health status
- MA risk scores still higher than FFS in 2016
  - However, risk score growth rates from 2015 to 2016 were roughly the same for MA and FFS

Diagnostic coding intensity impact on payment

- 2016 MA risk scores were 8% higher than FFS

Risk scores	2013	2014	2015	2016
Old model	**8 %**	9 %	10 %	*NA*
Payment blend	*NA*	***7 %***	***10 %***	*NA*
New model	*NA*	7 %	8 %	**8 %**

- After statutory minimum adjustment of 5.41%: MA risk scores in 2016 were 2 to 3% higher than FFS due to coding differences
- 2016 estimate incorporates use of encounter data

Source: MedPAC analysis of enrollment and risks score files.
Estimates are preliminary and subject to change.

MA quality and star ratings

- As part of MA update, usually report on year-over-year changes in MA quality, looking at a range of quality measures and the overall quality star ratings
- Unit of analysis is the MA contract—data reported at contract level and stars awarded at contract level
- Contract consolidation—the combining of separate contracts—changes the composition of enrollment in a contract
- After consolidation, a contract's performance cannot be compared to the performance of the same contract in preceding year(s)

Contract consolidations to attain bonus status

- Bonus payments for contracts at 4 stars or higher
- Star ratings determined at MA contract level and announced October of each year
- For public information purposes (Medicare Plan Finder), new star ratings posted during Oct-Dec annual election period
- For payment purposes, lag in star ratings for bonus payments
  - MA bids are due in June of each year for coming payment year
  - Bonuses based on most recently announced stars (October of the preceding year)
- Because bonus status of each contract is known at the time MA organizations bid—which is also the time companies make consolidation decisions—companies can move contracts from non-bonus status to bonus status via contract consolidations

Effect to date of contract consolidations

- In the past 5 years, 140 consolidations, including 108 contracts moving from non-bonus status (under 4 stars) to bonus status (4 stars or higher)
  - 4.1 million enrollees moved to bonus status over the 5 years—about 20 percent of total MA enrollment
  - While CMS reports percentage of enrollees in bonus plans is in 70 percent range, share would be lower if consolidations had not occurred and contracts' actual star ratings used
- Highest activity at the end of 2017, with 17 contracts moved to bonus status, affecting 1.4 million enrollees—moving 8 percent of total enrollment to bonus status

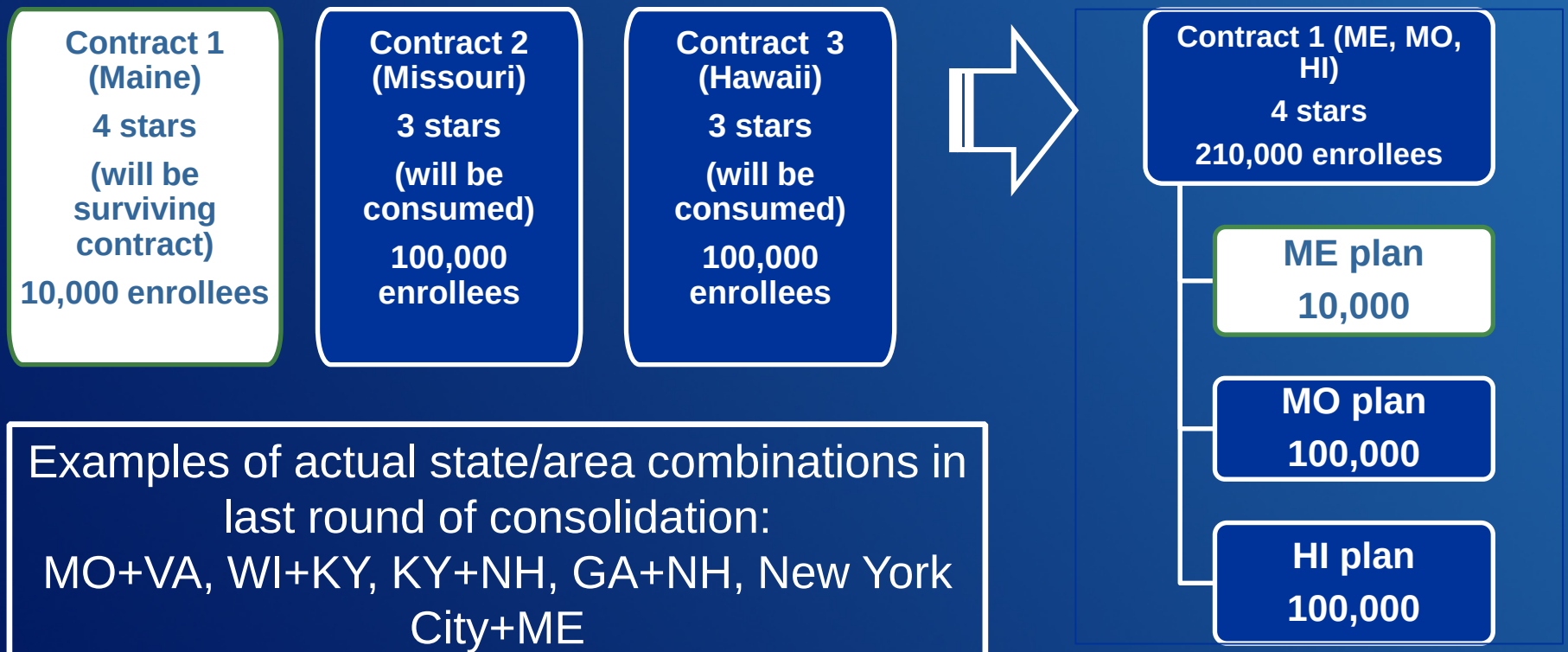
Contract configurations before and after consolidation (illustrative example)

Prior to consolidation:

3 contracts, 3 states

After consolidation:

1 contract, 3 states, 3 plans



Examples of actual state/area combinations in last round of consolidation:
MO+VA, WI+KY, KY+NH, GA+NH, New York City+ME

Concerns with contract consolidation to boost star ratings

- Increased program expenditures
- Inaccurate consumer information on quality in Medicare Plan Finder when surviving contract stars used instead of consumed contract stars
- Quality data not representative of performance in local area
- Unfair competitive advantage in a given market in comparative star ratings and rebates

Not a short-term expenditure issue because contracts can be re-consolidated

Contract(s)	End of 2013 consolidations	End of 2014	End of 2015/2016	End of 2017	Year 2018
H0001, H0002 under 4 stars	**Consumed by H0003**				
H0004 through H0020--17 contracts	Operating (at 3.5 stars)	**Consumed by H0003**			
H0003 (large enrollment)	Of 3 contracts, surviving contract (at 4.5 stars)	Of 20 contracts, surviving contract (at 4.5)	Dropped to 4 stars (2016 rating) for 2017 payments	Dropped to 3.5 stars, non-bonus status for 2018 payments. **Consumed by H0021.**	
H0021 (small enrollment)	Operating, at 3.5 stars	Operating, at 4.5 stars	Operating, at 4.5 stars	Surviving contract (is at 4 stars)	Sole surviving contract of 21 original contracts

After a large contract, H0003, consumes 19 contracts but then drops below 4 stars, H0021 (a small contract at 4 stars) in turn consumes H0003 (and the 19 contracts that H0003 had consumed)

Addressing the problem

- Immediate solution whereby star ratings based on pre-consolidation configuration in most cases
- Continue to have quality data reported under pre-consolidation configuration
- Move to quality reporting at the local geographic level

Conclusion

- Questions?
- Discussion of draft recommendations