Medicare Advantage: Calculating benchmarks and coding intensity

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MEDPAC

Today's presentation

- MA risk adjustment
- MA coding intensity
- How MA benchmarks are set
- Which FFS spending data should be used to set benchmarks

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
- After 1 year in FFS, risk scores for beneficiaries who switched into MA increased
  - 6% faster than FFS stayers in first year
  - 2% faster than FFS stayers each subsequent year

Diagnostic coding intensity impact on payment

- MA risk scores used for payment were 10% higher than FFS in 2015

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

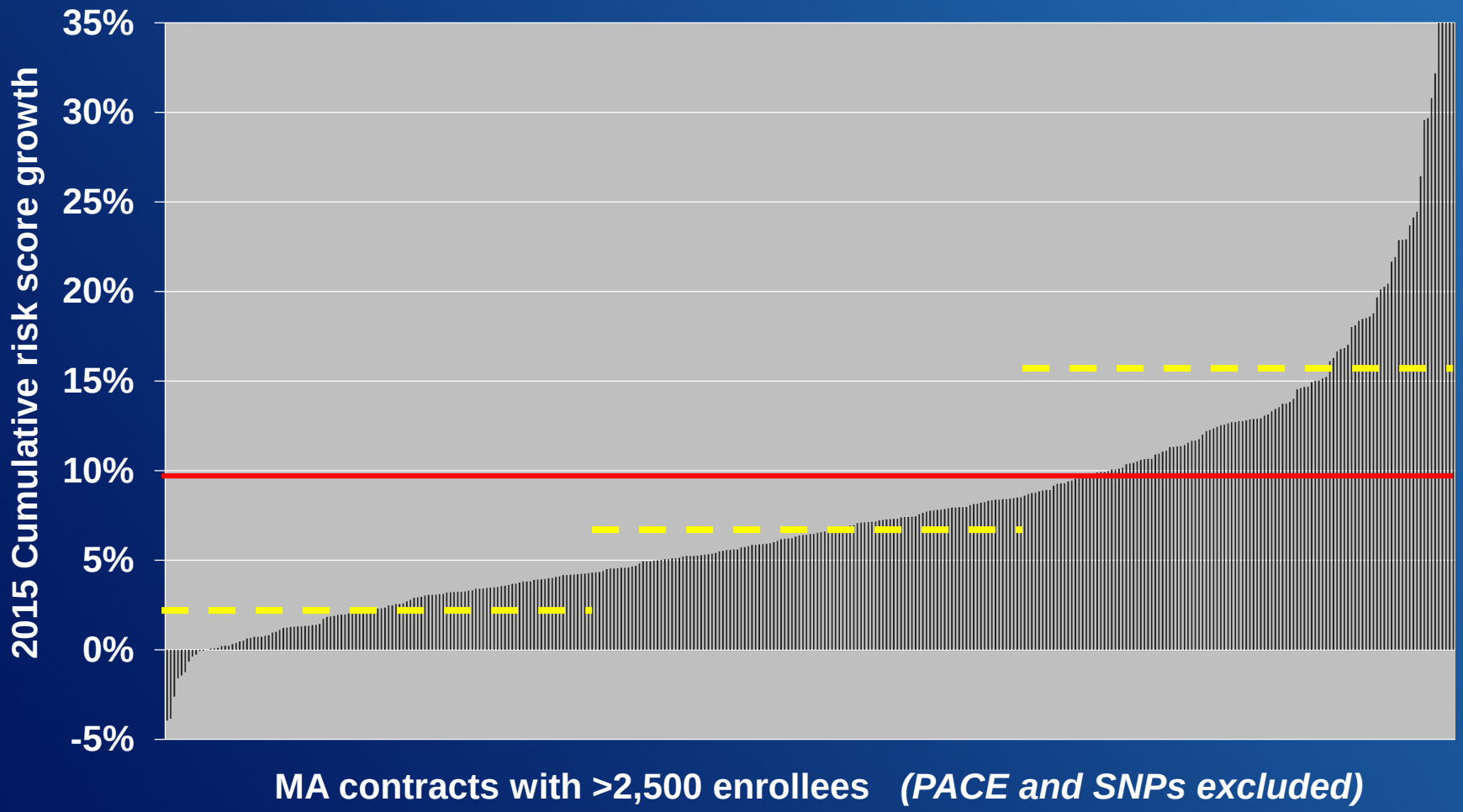
- CMS reduced all MA payments in 2015 by statutory minimum factor 5.16 percent
- After statutory adjustment, 2015 MA risk scores 4% higher than FFS due to coding

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

MedPAC 2016 recommendation

- Develop a risk adjustment model that uses two years of FFS and MA diagnostic data
  - *1 to 2 percent overall impact & enhanced equity*
- Exclude diagnoses only documented through health risk assessments from risk adjustment
  - *2 to 3 percent overall impact & enhanced equity*
- Apply a coding adjustment that fully and equitably accounts for the remaining differences in coding between FFS and MA
  - *5 to 7 percent overall impact*

Equitably addressing remaining coding intensity impact



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

How Medicare benchmarks are set

- Based on per-capita, risk-adjusted Medicare FFS spending
- Counties divided into FFS spending quartiles (115%, 107.5%, 100%, and 95%)
- Quartile value multiplied by FFS to get the benchmark

Measuring county-level FFS spending for use in MA benchmarks

- CMS calculates average per capita FFS Part A and Part B spending for each county to set the benchmarks
- Mismatch in FFS spending data used
  - MA benchmarks are based on spending of all FFS beneficiaries (100% of FFS beneficiaries)
  - MA enrollment allowed only for beneficiaries with both Part A and Part B (87% of FFS beneficiaries)

Issues with including beneficiaries with Part A-only in benchmark calculations

- Understates benchmarks because 12% of all FFS beneficiaries are Part A-only, and they cost less than those with both Part A and Part B
- The share of Part A-only varies by county
- The average share of Part A-only is increasing

Medicare beneficiaries with different enrollment status, 2009-2015 (in percent)

	2009	2010	2011	2012	2013	2014	2015
Managed Care/All Medicare	24.0	24.6	25.3	26.7	28.3	30.2	31.6
Part A and Part B / all FFS	88.8	88.6	88.3	87.7	87.3	87.0	86.8
Part A not Part B / all FFS	10.2	10.4	10.8	11.5	11.8	12.1	12.4
Part B not Part A / all FFS	1.0	1.0	0.9	0.9	0.8	0.8	0.8

Use only beneficiaries with A and B in FFS calculation for benchmarks?

- Some counties are affected more than others
- As MA penetration increases, the proportion of Part A-only will grow and FFS calculations will become less reflective of MA enrollment

Implications of using only beneficiaries with A and B

- Payments to MA plans would likely rise about 1 percent, or about $20 billion over 10 years
- The benchmarks in some counties with high MA penetration (and high shares of Part A-only) could rise by up to 3 percent, while the benchmarks of counties with relatively low shares of Part A-only might not rise at all

Commission Discussion

- Is there Commission interest in making a recommendation to calculate MA benchmarks using FFS beneficiaries enrolled in both Part A and Part B that would increase Medicare spending?