Advising the Congress on Medicare issues

The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans

Luis Serna, Andy Johnson, and Eric Rollins

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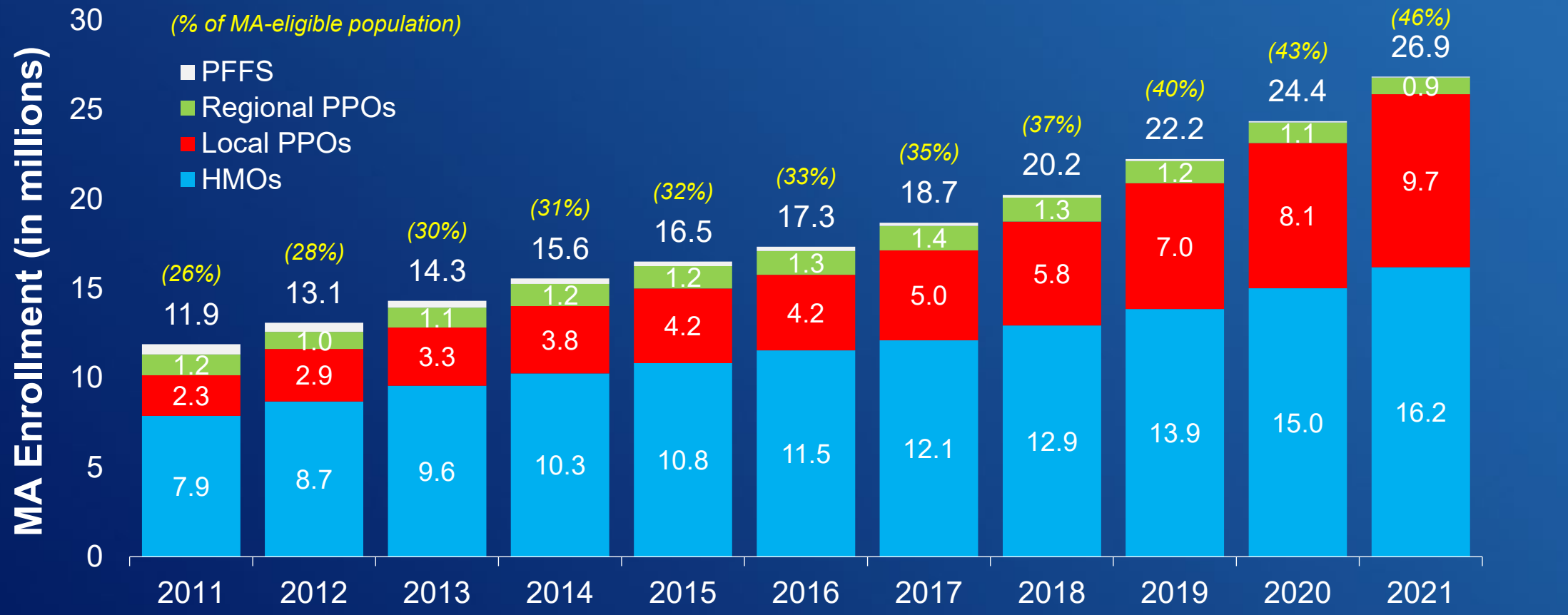
Today's presentation

- Status report on Medicare Advantage (MA) enrollment, availability, benchmarks, bids, and payment
- Update on coding intensity, MA quality, and the impact of the COVID-19 public health emergency on MA
- Mandated report on dual-eligible special needs plans

In 2021, 46% of eligible beneficiaries enrolled in MA plans



Notes: MA (Medicare Advantage), ACA (Affordable Care Act of 2010), PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization). MA-eligible beneficiaries have both Part A and Part B coverage. PFFS plans enrolled less than 1 million beneficiaries in each year. ACA benchmark reductions began in 2012 and were fully implemented in 2017.
Source: CMS enrollment data, July 2011-2021

Estimates preliminary and subject to change

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MA plans available to nearly all Medicare beneficiaries; number of plan choices increasing

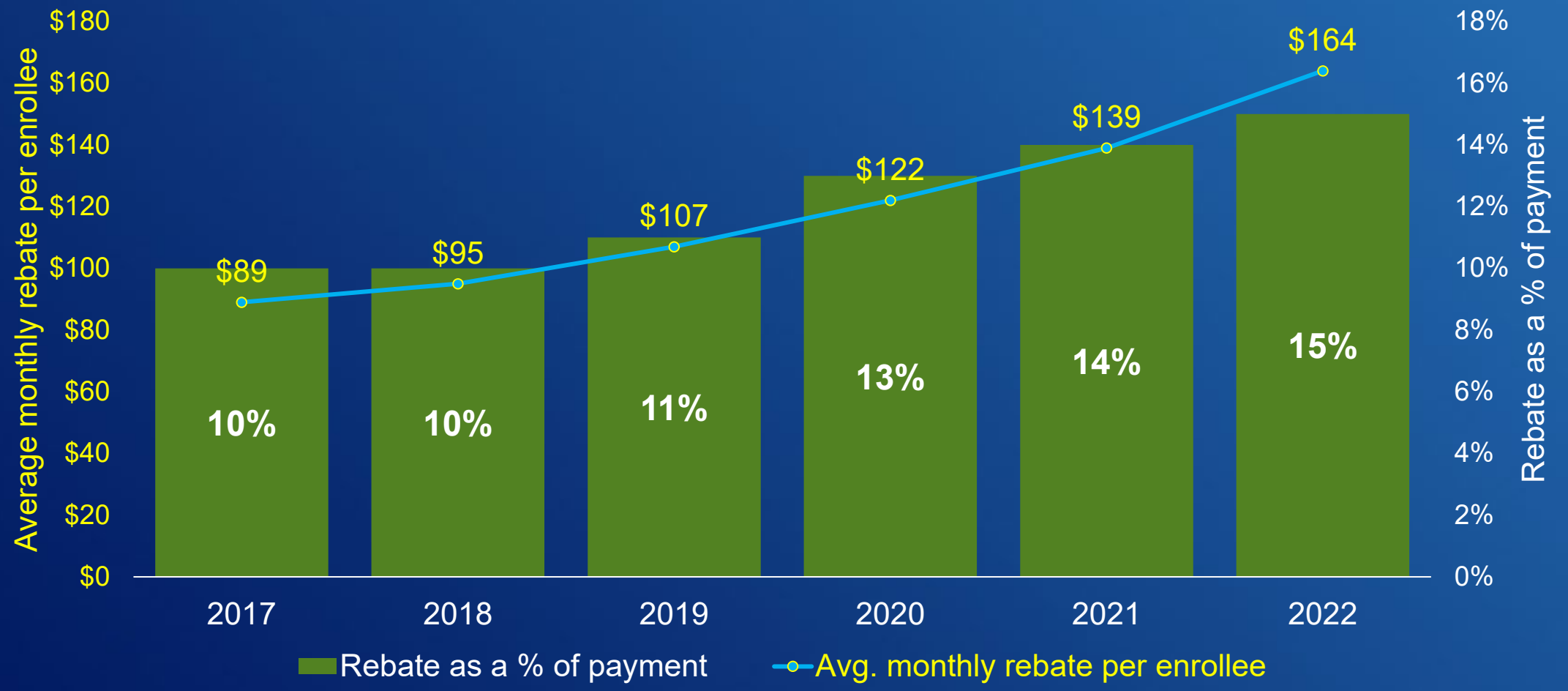
Plan availability*	2017	2018	2019	2020	2021	2022
Any MA plan	99%	99%	99%	99%	99%	**99%**
Zero-premium plan w/Part D	81	84	90	93	96	**98**
Avg. number of choices (beneficiary-weighted)	18	20	23	27	32	**36**

*Medicare beneficiaries with a non-employer, non-Special Needs MA plan available
Source: CMS enrollment data and plan bid submissions.

MA plan payment policy

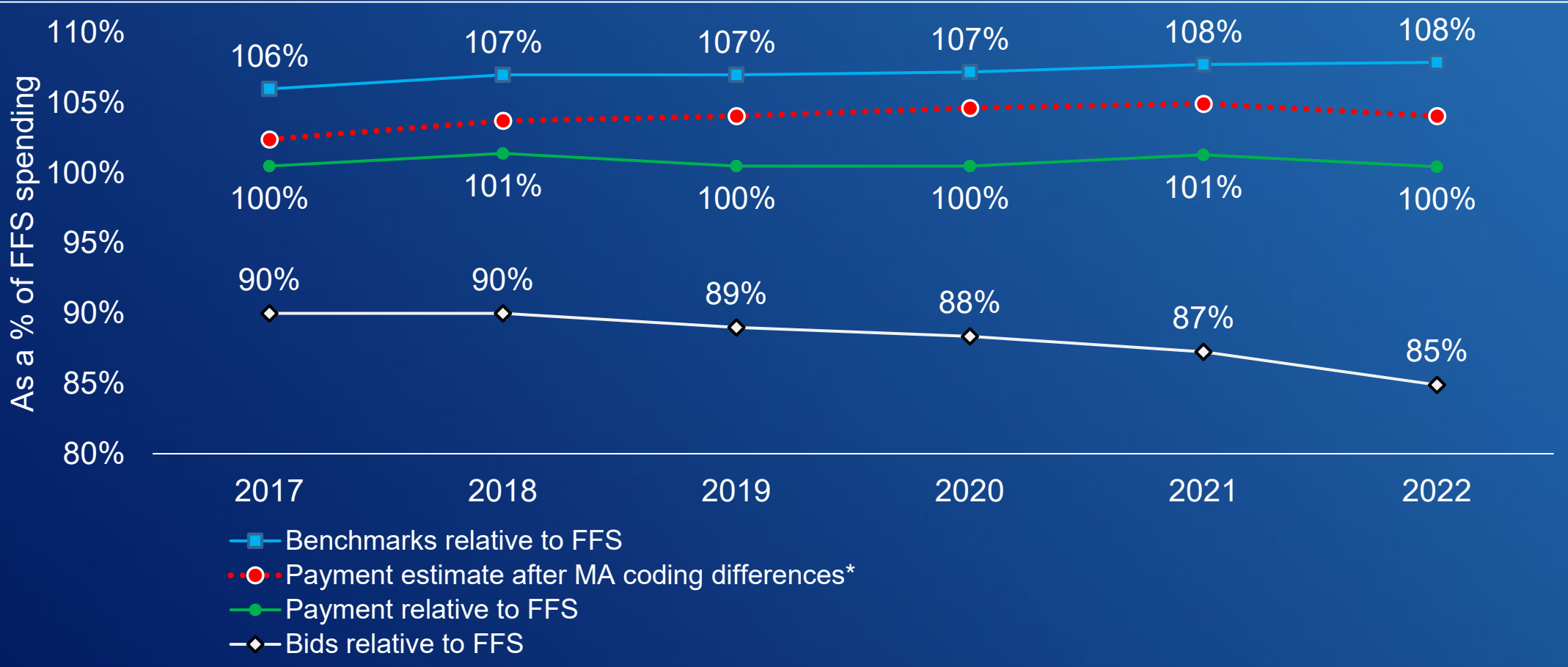
- Payments based on plan bids, benchmarks (county-based and risk-adjusted), and quality scores
- Benchmarks range from 115% of FFS in lowest-FFS spending counties to 95% of FFS in highest-spending counties
- Benchmarks are increased for plans based on overall quality scores
- If bid < benchmark, plans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

Level of monthly rebates reached historic high in 2022



Source: MedPAC analysis of MA bid data.
Estimates are preliminary and subject to change

MA bids at historic low relative to FFS, but MA payments continue to be above FFS in 2022



*Coding differences in 2021 and 2022 reflect 2020 levels (the most recent available data). Includes estimate of MA employer plan payments.
Note: FFS (fee-for-service). Benchmark and payment percentages include quality bonuses. Estimates preliminary and subject to change.
Source: Analysis of MA bid and rate data.

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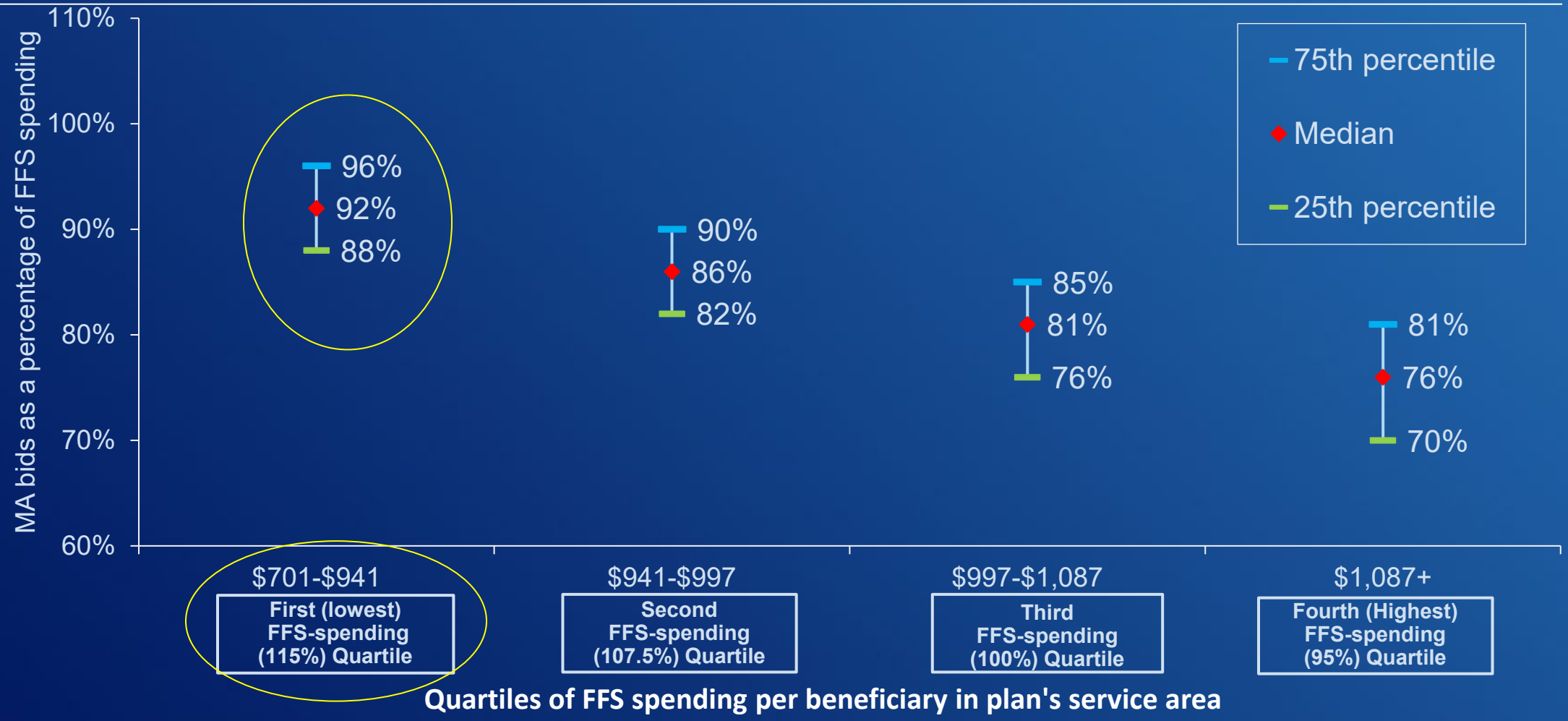
Even in the lowest-spending areas, most MA plans bid below local FFS spending in 2022



Note: FFS (fee-for-service). Benchmark and payment averages within each quartile include quality bonuses and are shown as a percentage of local FFS spending. Estimates preliminary and subject to change.
Source: Analysis of MA bid and rate data.

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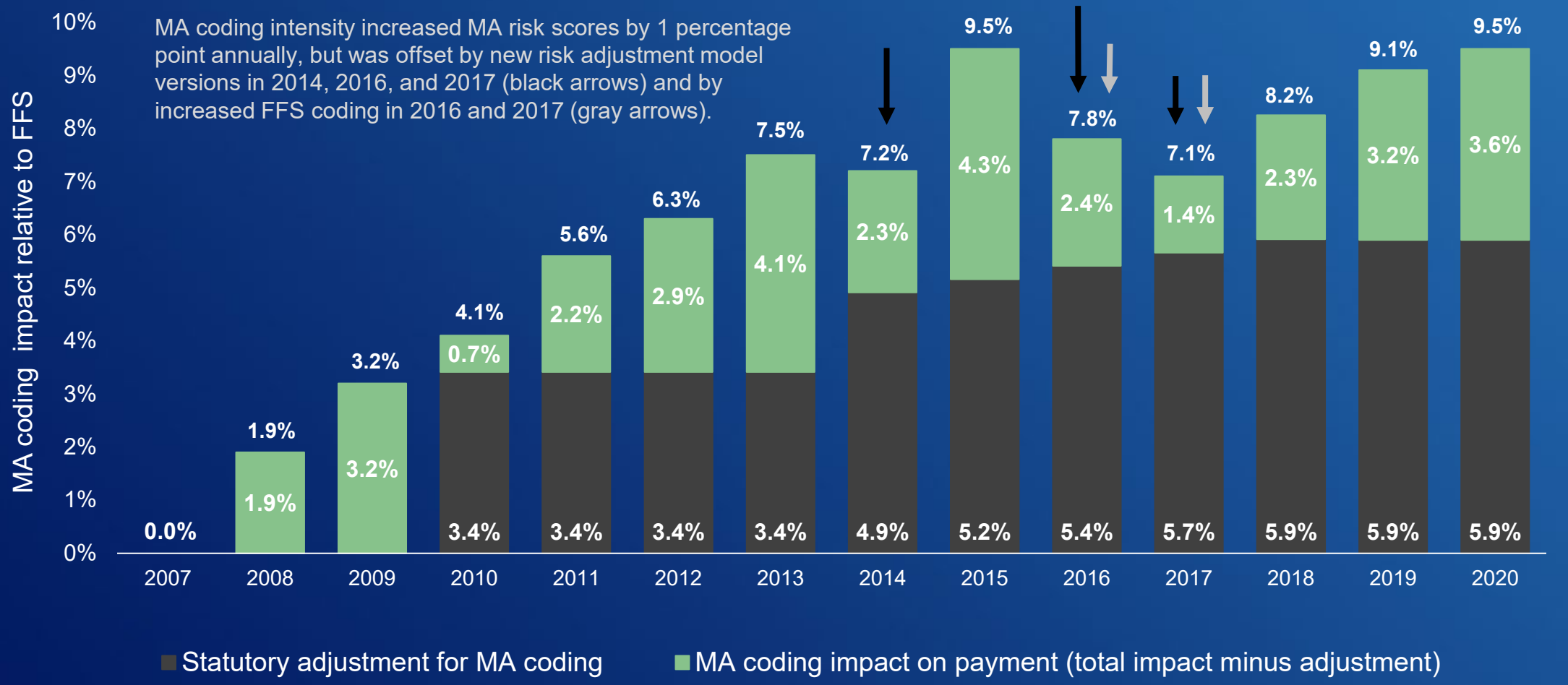
MA coding generated excess payments in 2020

- Differences in diagnostic coding between FFS and MA
  - FFS: Little incentive to code diagnoses
  - MA: Financial incentive to code more diagnoses
  - Leads to greater MA risk scores for equivalent health status
- 2020 MA risk scores were about 9.5 percent higher than FFS
- After accounting for CMS coding adjustment of 5.9 percent:
  - 2020 MA risk scores were more than 3.6 percent higher than FFS due to coding differences, generating about $12 billion in excess payments to MA plans

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

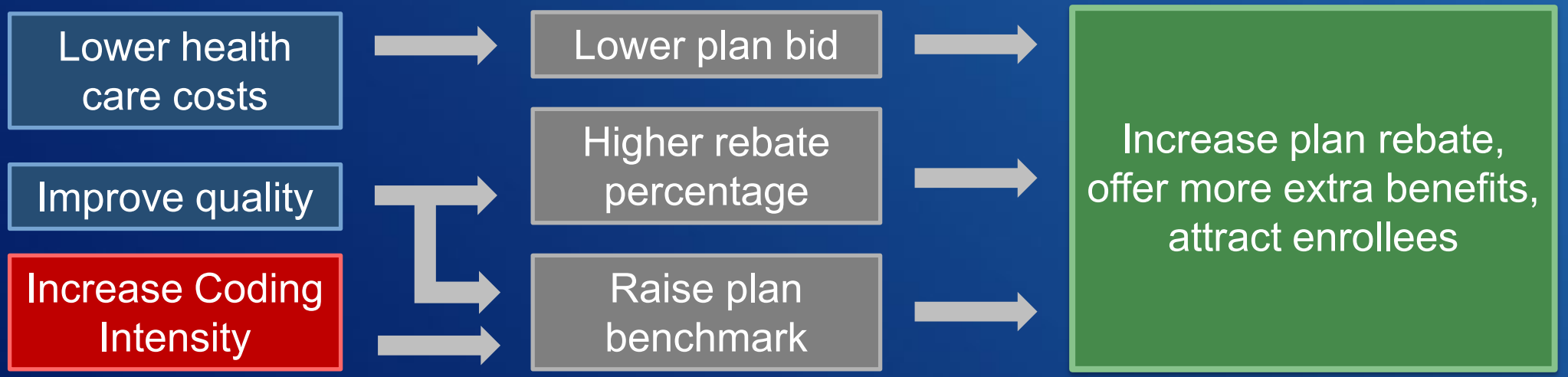
Impact of MA coding intensity continues to grow



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

MA coding intensity undermines plan incentives to improve quality and reduce costs

- Rebates are one of the primary ways that plans compete because they fund extra benefits that attract enrollees
- Rebate = (Benchmark − Bid) × Rebate percentage



Rebates are only available for plans bidding below their benchmark, which is nearly all plans in 2022.

Illustrative example: Coding intensity undermines plan incentives, provides a competitive advantage

	Reference plan	High coding intensity plan	Quality improving plan	Cost reducing plan
Annual plan bid	$9,000	9,000	9,000	**8,430 (6.3% cost reduction)**
Annual plan benchmark	$11,400	**11,970 (5% higher risk scores)**	**11,970 (5% quality bonus)**	11,400
Rebate percentage	65%	65%	65%	65%
Annual plan rebate	**$1,560**	**1,930**	**1,930**	**1,930**

Compared to reference plan:

1. Coding intensity produces a competitive advantage
2. All 3 strategies produce equivalent increase in plan rebates

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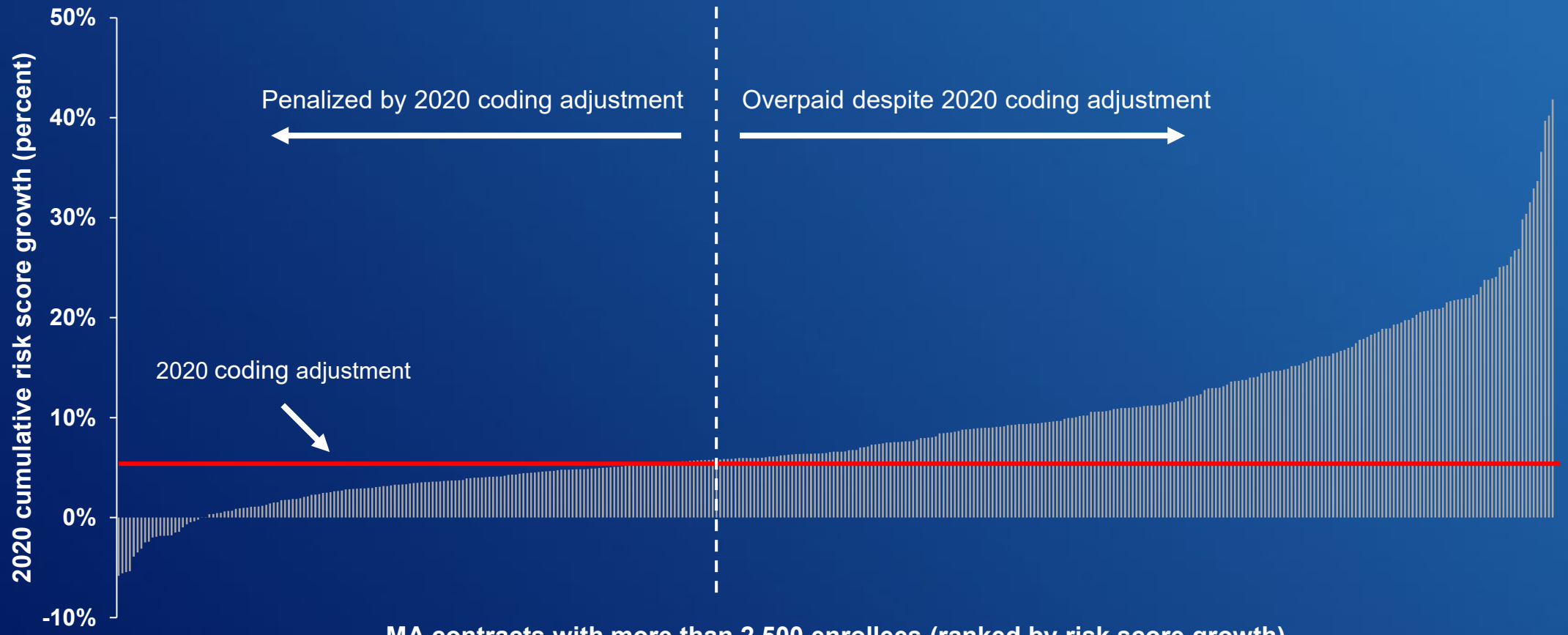
Calculated dollar values are rounded to the nearest $10. In this example, the High quality plan is assumed to increase its star rating such that it receives a quality bonus increase to its benchmark, but does not receive an increase to its rebate percentage.

Coding intensity generates payment inequity



MA contracts with more than 2,500 enrollees (ranked by risk score growth)
Excludes PACE contracts and special needs plans

Program of All-inclusive Care for the Elderly (PACE).
Source: MedPAC analysis of enrollment and risks score files. Estimates are preliminary and subject to change.

Addressing MA coding intensity

- The Commission's recommendation addresses underlying causes of coding intensity *(March 2016)*
  - Remove health risk assessments (HRAs) from risk adjustment
  - Use two years of MA and FFS Medicare diagnostic data
- Chart reviews and HRAs are key drivers of coding intensity
  - We estimate that chart reviews and HRAs account for nearly two-thirds of excess payments to MA plans
  - Use of chart reviews and HRAs varies substantially within MA, contributing to coding intensity variation across plans

Office of Inspector General (OIG). Source: MedPAC analysis of OIG report findings. Estimates are preliminary and subject to change.
Office of Inspector General, Department of Health and Human Services. 2021. *Some Medicare Advantage companies leveraged chart reviews and health risk assessments to disproportionately drive payments*. OEI-03-17-00474. Washington, DC: OIG.

Quality in MA cannot be meaningfully evaluated

- Quality bonus program (QBP) is not a good basis of judging quality for the 46 percent of Medicare beneficiaries in MA
  - Large and dispersed contracts, exacerbated by consolidations
  - Too many measures, some based on small sample
  - Cannot be compared to FFS in local market
- QBP accounts for $11 to $12 billion annually in MA payments
- Under relaxed PHE rules, 90 percent of MA enrollees in a quality bonus plan, generating a payment windfall for plans in 2023
- Commission recommended replacing the QBP with an improved value incentive program *(June 2020)*

Public health emergency (PHE).

Impact of COVID-19 public health emergency

- Tragic effects on beneficiaries and the health care workforce and material effects on providers
- In 2020, record low utilization increased plan profits
- For 2021, prospectively set payment rates assumed utilization would be higher, likely boosting profits for a second year
  - These effects have been uneven geographically and over time
- Plans remain concerned about delayed care rebounding, but that has not borne out yet

Public health emergency (PHE).

Summary: MA program is extremely robust, but policy reforms are urgently needed

- If enrollment trend continues, the majority of Medicare beneficiaries with Part A & B will be enrolled in MA by 2023
- The average beneficiary has a choice of 36 plans, and the average MA enrollee has access to nearly $2,000 in annual extra benefits
- However, Medicare is paying MA plans 4 percent more than FFS Medicare for similar enrollees
- The Commission has recommended addressing flaws in coding intensity, the quality system, benchmarks, and MA encounter data completeness (not discussed today)

Mandated report on dual-eligible special needs plans (D-SNPs)

- D-SNPs are specialized MA plans that serve beneficiaries who receive both Medicare and Medicaid (dual eligibles)
- The Bipartisan Budget Act of 2018 (BBA) made three important changes to D-SNPs:
  - Made D-SNPs a permanent part of MA program
  - Required D-SNPs to meet new standards for integrating Medicare and Medicaid services (starting in 2021)
  - Required some D-SNPs to use a unified process for handling grievances and appeals (starting in 2021)

Under the BBA, D-SNPs must meet one of three standards for integration

- Plan notifies state about inpatient/SNF admissions for at least one high-risk group (coordination-only plans, ~57% of D-SNP enrollees)
- Plan qualifies as a HIDE SNP or FIDE SNP by providing Medicaid LTSS and/or behavioral health, but does not have exclusively aligned enrollment (~35% of enrollees)
- Plan qualifies as a HIDE SNP or FIDE SNP and has exclusively aligned enrollment (~8% of enrollees)

Note: SNF (skilled nursing facility), HIDE SNP (highly integrated dual-eligible special needs plan), FIDE SNP (fully integrated dual-eligible special needs plan), LTSS (long-term services and supports)

The BBA directs the Commission to periodically assess D-SNP performance

- Use HEDIS® data to assess plan performance (with CAHPS® data or encounter data as potential alternatives)
- Compare five types of plans that serve dual eligibles
  - The three types of D-SNPs defined in BBA
  - Medicare-Medicaid Plans
  - Other MA plans
- Provide a report every 2 years from 2022 to 2032 and then every 5 years starting in 2033

Note: HEDIS (Healthcare Effectiveness Data and Information Set), CAHPS (Consumer Assessment of Healthcare Providers and Systems). HEDIS® is a registered trademark of the National Committee for Quality Assurance. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.

Analytic approach for 2022 mandated report

- Used 2020 person-level HEDIS and plan enrollment data and 2021 D-SNP integration data
- Excluded “hybrid” measures that use medical record sampling because sample sizes are not large enough to generate reliable plan-level estimates
- Calculated plan-level HEDIS scores for 22 measures with 35 associated rates

Comparing HEDIS scores provides limited insight on the relative performance of D-SNPs

- Results were mixed – each plan type performed relatively well on some measures and relatively poorly on others
- The five plan types we compared have numerous differences that make it difficult to draw larger conclusions
- Available measures are largely process measures; we view measures tied to clinical outcomes and patient experience as more meaningful
- As noted earlier, measuring plan performance and quality in MA is challenging

Discussion

- Questions on the MA status report
- Questions on the mandated report on D-SNPs