



*Advising the Congress on Medicare issues*

# Medicare Advantage: Calculating benchmarks and coding intensity

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# Today's presentation

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

# MA risk adjustment

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- 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

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- 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 %  | <b>10 %</b> |

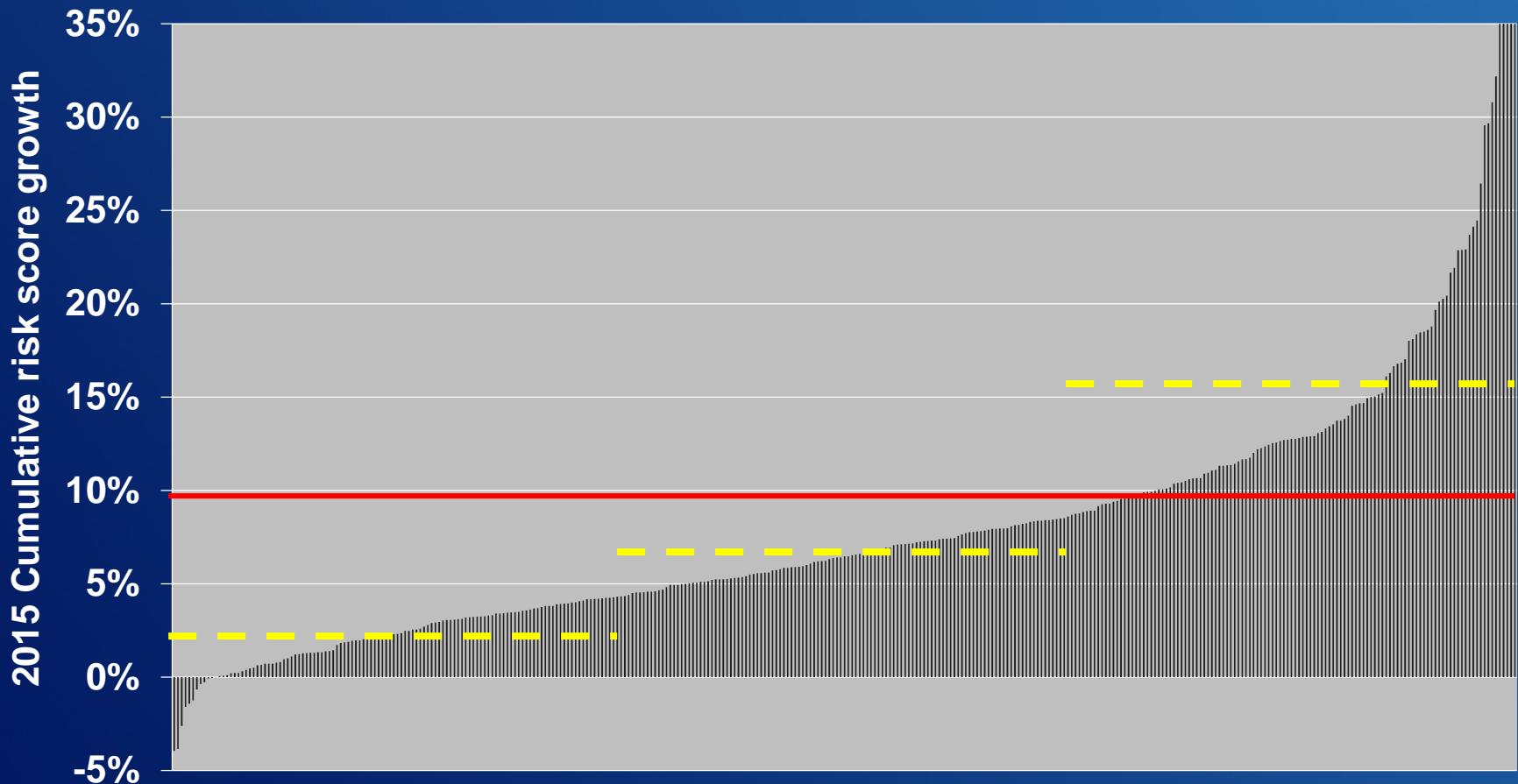
- CMS reduced all MA payments in 2015 by statutory minimum factor 5.16 percent
- After statutory adjustment, 2015 MA risk scores 4% higher than FFS due to coding**

# MedPAC 2016 recommendation

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- 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



MA contracts with >2,500 enrollees (PACE and SNPs excluded)

Source: MedPAC analysis of enrollment and risks score files.

Estimates are preliminary and subject to change.

# How Medicare benchmarks are set

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- 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

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- 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

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- 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 |
|---|------|------|------|------|------|------|------|
| <b>Managed Care/All Medicare</b>          | 24.0 | 24.6 | 25.3 | 26.7 | 28.3 | 30.2 | 31.6 |
| <b>Part A <u>and</u> Part B / all FFS</b> | 88.8 | 88.6 | 88.3 | 87.7 | 87.3 | 87.0 | 86.8 |
| <b>Part A not Part B / all FFS</b>        | 10.2 | 10.4 | 10.8 | 11.5 | 11.8 | 12.1 | 12.4 |
| <b>Part B not Part A / all FFS</b>        | 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?

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- 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

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- 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

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- 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?