

The Impact of the Medicare Advantage Benchmark Cap on Beneficiaries

FACT SHEET JANUARY 2017

Millions of Medicare Advantage beneficiaries in 4 or 5-Star rated plans are negatively impacted by the benchmark cap and do not receive the full benefits of a high quality plan.

Key Facts

- In Medicare Advantage, plans that earn a high Star Quality rating receive a quality bonus they must apply to enhanced benefits.
- In some counties, the benchmark cap prevents these high quality plans from receiving the quality bonus they earned.
- As a result, beneficiaries do not receive the enhanced benefits enabled by quality incentives.
- In 2016, over two million beneficiaries were denied enhanced benefits, including reduced cost sharing, due to the benchmark cap.
- In total, over three million Medicare Advantage beneficiaries are enrolled in counties impacted by the benchmark cap.

The Medicare Advantage Star Rating System Incentivizes Quality

- In Medicare Advantage, payments are tied to quality through a Star Rating system that rewards plans with a 4-Star rating or higher (on a 5-Star scale) with a Quality Bonus Payment (QBP).
- The QBP must directly benefit beneficiaries, and must be applied to reducing cost sharing or increasing benefits, such as dental or vision coverage or investments in disease management programs and innovations like telemedicine.
- The Star Rating system has been very effective at driving quality. In 2017, over 70% of MA enrollees are in 4-Star or higher, bonus-eligible plans, up from less than 20% in 2009.

The Benchmark Cap Undermines Quality Incentives

- The benchmark cap was enacted in the Affordable Care Act (ACA) and caps Medicare Advantage payment at the pre-ACA level (plus growth updates).
- Implementation of the benchmark cap policy prevents 4-Star or higher plans in certain counties from receiving the QBP they have earned. This results in millions of beneficiaries in these counties being denied the enhanced benefits enabled by quality incentives.
- There is broad bipartisan support in Congress, the Administration, and MedPAC. to address the benchmark cap issue.

The Benchmark Cap Negatively Impacts Beneficiaries

- In 2016, over two million beneficiaries enrolled in 4-Star or higher plans were denied additional benefits due to the benchmark cap.
- In total, over three million Medicare Advantage beneficiaries are enrolled in counties impacted by the benchmark cap, which means they would not receive additional benefits for enrolling in a high-quality Medicare Advantage plan.

Policy Recommendation

Congress or the Centers for Medicare & Medicaid Services (CMS) should remove the benchmark cap for 4-Star or higher plans to ensure all beneficiaries benefit from enrollment in high quality plans.

Coding and Payment in Medicare Advantage

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Key Facts

- Medicare Advantage plans are paid a capitated amount based on the average cost of FFS Medicare. That payment is risk adjusted for each enrollee based on health status.
- Medicare Advantage relies on diagnosis codes for payment. FFS Medicare relies on procedure codes for reimbursement.
- There are differences in coding patterns between Medicare Advantage and FFS Medicare, which are a function of the differences between the payment structure and care models.
- CMS reduces Medicare Advantage payments annually to account for coding differences between Medicare Advantage and FFS Medicare.
- The coding intensity adjustment is a 5.91% reduction per year in Medicare Advantage payments.

Policy Recommendation

To achieve stability and predictability in payment to Medicare Advantage, ensure adequacy of prospective, capitated payment, and enable plans and providers to have the data necessary for early intervention and care management, CMS should freeze the coding intensity adjustment at the current statutory minimum.

Medicare Advantage plans depend on stable payment and risk adjustment to ensure adequate resources are available to provide coverage for the care and treatment of enrollees.

Payment Model in Medicare Advantage

- In Medicare Advantage, health plans are paid a capitated, or fixed, prospective amount to cover care for enrollees. Medicare Advantage relies on risk scores to account for anticipated health costs for enrollees based on health status.
- Medicare Advantage plans submit diagnosis codes to the Center for Medicare & Medicaid (CMS). Then CMS adjusts capitated payments to plans for each enrollee based on his or her risk score. The risk score is calculated using patients' diagnoses and demographic data.

Coding Pattern Differences

- There are different diagnostic coding practices in Medicare Advantage and Fee-For-Service (FFS) Medicare, due to the different payment systems and care models.
- Medicare Advantage relies on diagnosis coding to adjust the prospective, capitated payment for each enrollee. Plans then take on the financial risk that the payment will be adequate to cover costs of care. FFS Medicare reimburses providers for services, procedures, or episodes of care already provided.
- FFS Medicare payment does not rely on the same degree of specificity of diagnoses.
- Medicare Advantage depends on risk data to enable care management and early interventions, engage patients, follow-up on clinical recommendations, address social and emotional barriers, and slow disease progression. Such care management is not typically available in FFS Medicare.

Coding Intensity Adjustment in Medicare Advantage

- Coding intensity refers to the difference in diagnostic coding patterns between Medicare Advantage and FFS Medicare.
- Medicare Advantage payment is based on FFS Medicare cost data. Since diagnosis coding practice is different between the two programs, CMS reduces Medicare Advantage payments by an annual percentage to bring Medicare Advantage coding in-line with FFS Medicare coding patterns.
- Since 2010, Congress requires CMS to apply a coding intensity adjustment to Medicare Advantage risk scores to account for this difference, resulting annual across-the-board reduction in Medicare Advantage payments.
- Per statute, the coding intensity adjustment increased from a 3.41% reduction in 2010 to a 5.91% reduction in 2018. The adjustment remains at an annual 5.91% reduction to risk scores for subsequent years.
- CMS has the authority to determine a reduction above the statutory minimum. To date, CMS has applied the minimum coding intensity adjustment required by law.

Key Facts

- Medicare Advantage plans are paid a capitated amount based on average cost of Fee-For-Service. It is then risk adjusted for each enrollee.
- Law requires CMS to conduct Risk Adjustment Audits (RADV) to verify data accuracy.
- Overpayments identified in RADV must be returned to the government. If fraud occurs, penalties and fines are applied.

Policy Recommendation

Risk Adjustment Data Validation (RADV) audits are part of the process used by CMS to ensure payment accuracy in Medicare Advantage. CMS should work with Medicare Advantage plans, providers, and other stakeholders to improve the transparency, efficacy, and accuracy of RADV without excessive burden on providers.

CMS verifies the accuracy of Medicare Advantage payments by conducting Risk Adjustment Data Validation (RADV) audits.

Medicare Advantage Payments

The Centers for Medicare & Medicaid Services (CMS) pays Medicare Advantage plans a monthly, per-person, fixed rate, also known as a capitated payment, to deliver care to Medicare beneficiaries. This capitated payment is based on county level average Fee-For-Service (FFS) Medicare cost and is then risk adjusted for each individual to account for differences in health, demographics, and other risk factors. Risk scores are subsequently reduced by the “coding intensity adjustment” applied annually, across-the-board to reduce the risk scores to account for the difference in coding patterns between FFS Medicare and Medicare Advantage.

Law Requires CMS to Audit Payments in Medicare Advantage

Law requires government agencies to identify, report, and reduce erroneous payments in all government programs and activities. In Medicare Advantage, this includes regular validation of payments based on risk scores.

Risk Adjustment Data Validation (RADV) Verifies Data Accuracy

- CMS conducts Medicare Advantage RADV activities to ensure the accuracy and integrity of risk adjustment data and risk adjusted payments.
- RADV is the process of verifying that diagnosis codes and other data submitted for payment by a Medicare Advantage plan are supported by medical record documentation.
- Medicare Advantage plans and providers develop, refine, and use sophisticated data systems and processes, as well as skilled personnel, to provide accurate data and to comply with CMS rules.

RADV is a Rigorous Process

- As with other government programs, audits are conducted to catch fraud and abuse and ensure such erroneous payments are returned to the government.
- For each RADV audit cycle, CMS selects a subset of plans to review and then samples enrollee records and extrapolates findings to all payments.
- During the RADV process, Medicare Advantage plans are required to provide CMS access to facilities and records used in the determination of amounts payable under Medicare Advantage.
- Any overpayments found through RADV (e.g. from miscoding diagnoses) must be returned by Medicare Advantage plans to the government. If fraud is found, additional fines and penalties may be applied.

Key Facts

- SNPs are a type of Medicare Advantage plan tailored to serve high-cost, high-need beneficiaries.
- Over 2 million beneficiaries are in nearly 600 SNPs nationwide.
- D-SNPs serve beneficiaries dually eligible for Medicare and Medicaid.
- C-SNPs serve beneficiaries with a severe or disabling chronic condition.
- I-SNPs serve beneficiaries residing in a nursing home or living in a community requiring nursing care at home.
- Action to reauthorize SNPs is required by December 2018. Better Medicare Alliance supports permanently authorizing SNPs.

Special Needs Plans (SNPs) are a type of Medicare Advantage plan tailored to serve the health care system's fastest growing population – high-cost, high-need beneficiaries.

What is an SNP?

SNPs are a type of Medicare Advantage plan that are paid and regulated in the same way as other Medicare Advantage plans, but have the authority to provide specialized care to serve beneficiaries who are dually-eligible for Medicare and Medicaid, have certain chronic conditions, or receive long-term care in an institutional setting such as a Skilled Nursing Facility. In addition to providing all Medicare Part A and Part B benefits, SNPs must also exceed these core benefits by providing reduced cost sharing, individualized care plans, and other tailored benefits related to mental health, social services, and wellness.

Primary Types of Medicare Advantage SNPs

Over 2.3 million beneficiaries are enrolled in nearly 600 SNPs nationwide.

- **Dual-Eligible SNPs (D-SNPs):** Serve beneficiaries eligible for coverage under both Medicare and Medicaid, known as dual-eligible beneficiaries - 377 D-SNPs serve 1.9 million beneficiaries.
- **Chronic Condition SNPs (C-SNPs):** Serve beneficiaries with a disabling chronic condition, such as End Stage Renal Disease (ESRD), severe diabetes, dementia, or cancer - 123 C-SNPs serve over 330,000 beneficiaries.
- **Institutional SNPs (I-SNPs):** Serve institutionalized beneficiaries residing in a long-term care facility, such as a Skilled Nursing Facility, or living at home but requiring an institutional level of care - 83 I-SNPs serve nearly 63,000 beneficiaries.¹

SNPs Provide High Quality Care

- SNPs provide care tailored to high-need, complex beneficiaries through care management tools, such as care managers, interdisciplinary teams, specialized provider networks, enhanced home and community-based services, and data sharing across health plans and providers.
- SNPs must seek approval for a "Model of Care," which is approved by the National Committee for Quality Assurance (NCQA). The SNP Model of Care is a quality improvement tool used to ensure the needs of each beneficiary are being identified and addressed.
- MedPAC also reported that Individuals with only Part A have much lower costs than beneficiaries with both Part A and Part B coverage, which further distorts the accuracy and adequacy of the benchmark.

SNPs Need Certainty

- SNPs have been recognized as a valuable care delivery model for high-need individuals. SNPs have been reauthorized regularly by Congress since 2003. Additionally, both the Senate Finance Committee Chronic Care Working Group and MedPAC have both recommended permanent reauthorization of the program.
- In April 2016, the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) extended the SNP program through December 31, 2018. Without Congressional action, SNP authority will expire December 31, 2018.

Policy Recommendation

SNPs should be permanently authorized to ensure beneficiaries have access to the quality, coordinated, and high-value care offered by SNPs. Without Congressional action, SNP authority will expire in 2018. Better Medicare Alliance supports permanently authorizing SNPs.

Medicare Advantage Employer Retiree Plans

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Key Facts

Over 3.5 million retirees nationwide, 20% of Medicare Advantage beneficiaries, are in EGWPs. Retiree enrollment continues to grow, nearly doubling since 2010.

- Medicare Advantage employer plans provide the following benefits to retirees:
- Comprehensive Medicare coverage as well as supplemental benefits such as vision, hearing, and dental.
- Access to providers nationwide.
- Lower premiums and limits in out-of-pocket costs.
- Improved outcomes.

A continued reduction in payment to retiree Medicare Advantage plans will likely cause:

- Higher premiums and out-of-pocket costs for medical services and prescriptions.
- Reduced access to supplemental benefits.
- Reduced investments in innovations.

BMA Policy Recommendations

Better Medicare Alliance supports ensuring the availability of EGWPs by freezing the implementation of the new payment methodology and calculating bid-to-benchmark ratios separately for Health Maintenance Organizations (HMO) and Local Preferred Provider Organizations (PPO) plans. CMS should also engage in greater promotion of EGWPs by targeting informational materials and outreach to entities that represent eligible beneficiaries, private employers, and state and local governments.

Over three and a half million beneficiaries are enrolled in Medicare Advantage Employer-Group Waiver Plans (EGWPs), which are employer-sponsored health plans for retirees that provide health coverage through the Medicare Advantage program.

Retiree Coverage in Medicare Advantage Today

Medicare Advantage employer plans, officially known as Employer-Group Waiver Plans (EGWPs), allow employers, governments, and labor unions to provide comprehensive Medicare Advantage coverage to their retirees. Medicare Advantage employer plans provide Medicare Part A and B benefits, as well as supplemental benefits. Employers typically pay Part B premiums and co-pays to reduce cost sharing for retirees.

EGWPs offer benefits tailored to specific groups of retirees, which are then available wherever the beneficiary may live. Employer-sponsored Medicare Advantage plans successfully enable over 3.5 million retirees nationwide to maintain consistent benefits and contain costs for industries, governments, and beneficiaries.

Potential Future Changes to Retiree Coverage

In 2016, the Centers for Medicare & Medicaid Services (CMS) finalized a proposal to terminate the previous EGWP bid process and replace it with set payment amounts for EGWPs in each county. CMS planned to phase-in the new methodology that would reduce EGWP payments by an estimated 2.5% over two years, beginning in 2017. Given stakeholder concerns, CMS decided to partially freeze implementation of the methodology at the 2017 level for 2018.

What Changes Could Mean for Retirees

Fully phasing-in EGWP payment cuts, as proposed by CMS could result in:

- **Disruption for over 3.5 million retirees who depend on Medicare Advantage EGWP coverage:** In 2017, CMS set EGWP payment rates based on an enrollment-weighted county bid to benchmark ratio calculated using non-employer data. This change was projected to reduce EGWP payments by 2.5%.
- **Reduction in benefits for retirees in Medicare Advantage:** Further payment reductions to EGWPs would likely mean reductions in supplemental benefits such as vision, dental, and hearing, and increases in cost sharing for current and future beneficiaries. It could also lead to reduced access to new innovations, like telehealth and home care for enrollees.
- **Fewer choices for retirees:** Further reductions to EGWPs could cause employers to decide not to offer Medicare Advantage plans to their retirees. Losing access to Medicare Advantage means fewer benefits and less access to the high-quality care Medicare Advantage provides – including early intervention, care coordination, and disease management for individuals with chronic conditions.

Encounter Data in Medicare Advantage

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Key Facts

- Medicare Advantage encounter data are detailed records about Medicare Advantage enrollees health care.
- CMS uses encounter data to determine and validate payments, as well as to evaluate the MA program.
- CMS has been moving towards greater use of encounter data for payment, but moved back to 15% use in 2018, down from 25% in 2017.

BMA Policy Recommendations

CMS should ensure a thoughtful transition by delaying the phase-in of encounter data as a diagnosis source until data accuracy and processes are verifiable and reliable. Before moving forward, CMS should work with stakeholders, in a transparent way, to evaluate data, address implementation barriers, and analyze stakeholder impacts to better assure payments are based on accurate risk scores.

Medicare Advantage encounter data is intended to capture the details of a Medicare Advantage beneficiary's health and treatment based on "encounters" with clinicians. This data is used to understand the health status of enrollees.

Encounter Data

- Encounter data contains detailed records of health care provided to Medicare Advantage beneficiaries, including clinical diagnoses, care, and treatments.
- Medicare Advantage encounter data captures aspects of a beneficiary's health care, providing different information than in claims data used in Fee-For-Service (FFS) Medicare. In addition, the Centers for Medicare & Medicaid Services (CMS) reviews and pays FFS Medicare claims, whereas Medicare Advantage plans review and pay encounter data claims and report them to CMS in a standardized format.
- CMS is planning to implement the use of an Encounter Data System (EDS) with the goal of replacing the claims data to collect and understand the health care provided to Medicare Advantage enrollees, as well as to compare care provided across Medicare Advantage plans

Encounter Data in Medicare Advantage

- **Encounter Data to Report Diagnoses:** CMS began collecting encounter data from Medicare Advantage plans in 2012.
- **Oversight and Analyses:** CMS uses encounter data to determine and validate payments to Medicare Advantage. CMS can also use encounter data to evaluate care quality and overall program integrity in Medicare Advantage.
- **Risk Adjustment:** In 2015, CMS started using diagnoses from encounter data to calculate risk scores for Medicare Advantage beneficiaries, which affect payment. Prior to 2015, CMS calculated risk scores exclusively based on diagnoses submitted by plans through the Risk Adjustment Processing System (RAPS). CMS is mandated to move from RAPS to EDS to calculate beneficiary risk scores

Transition to Medicare Advantage Encounter Data

- The goal is to move to exclusive use of encounter data by 2020.
- In 2016, CMS based 10% of the Medicare Advantage beneficiary risk score calculation on diagnoses submitted through the EDS and 90% based on the RAPS.
- Plans and providers experienced technical issues with the use of encounter data, creating uncertainty about the accuracy of identification of diagnoses for beneficiaries. Stakeholders and CMS questioned the readiness of EDS.
- In 2017, the blend was 25% EDS and 75% RAPS to determine risk scores. CMS planned to maintain the 2017 percentages in 2018. However, Due to concerns about data accuracy, CMS reversed this shift and reduced the percentage mix to 15% EDS and 85% RAPS.

Improve Medicare Advantage Payment Accuracy by Using Both Part A and B FFS Medicare Data

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Key Facts

- CMS should improve Medicare Advantage payment accuracy by using only FFS Medicare data from individuals with both Part A and Part B for benchmark calculation.
- A Medicare Advantage beneficiary must be enrolled in both Part A and Part B.
- This change would likely result in a 1% increase in Medicare Advantage payments.
- An estimated 12% of FFS Medicare beneficiaries have only Medicare Part A or only Part B.
- Individuals with only Part A have much lower costs than beneficiaries with both Part A and Part B, which distorts the Medicare Advantage benchmark.

Policy Recommendation

CMS or Congress should improve Medicare Advantage payment accuracy and beneficiary access to care by calculating the Medicare Advantage benchmark using FFS Medicare data for beneficiaries enrolled in both Part A and Part B.

The Medicare Payment Advisory Commission (MedPAC) identified a growing trend in payment inaccuracy that could affect beneficiary access to affordable, high quality Medicare Advantage. MedPAC recommended that this inaccuracy would be corrected by using Traditional Fee-For-Service (FFS) Medicare data from individuals with both Medicare Part A and B to calculate the benchmark.

Medicare Advantage Relies on Payment Accuracy

- Medicare Advantage payment is based on a capitated monthly payment to care for each beneficiary. These payments are risk adjusted to account for each beneficiary's demographic and disease profile.
- The Medicare Advantage capitated payments are based on county benchmarks, which are calculated annually by the Centers for Medicare & Medicaid Services (CMS) using per capita county-level FFS Medicare spending data.

The Current Payment Formula Includes Inaccurate Data

- The current benchmark calculation includes all FFS Medicare spending in a county. This means even data for FFS Medicare beneficiaries enrolled only in Part A (hospital services) or Part B (provider services) is included.
- This is problematic because to enroll in Medicare Advantage, a beneficiary must be enrolled in both Part A and Part B. Therefore, the benchmark should represent estimated cost for an individual spending on both Part A and Part B services.
- By including FFS Medicare data for individuals who only have Part A or Part B coverage in the Medicare Advantage benchmark calculation, the benchmark is distorted and payment is inaccurate.

Medicare Advantage Benchmark Inaccuracies Are Growing

- According to the MedPAC the share of FFS Medicare beneficiaries only enrolled in Part A or Part B is growing. Currently, over 12% of FFS Medicare beneficiaries have only Medicare Part A or Part B. In some counties, the number of FFS Medicare beneficiaries in only Part A or Part B is as high as 25%. As this trend grows, this distortion will become worse.
- MedPAC also reported that Individuals with only Part A have much lower costs than beneficiaries with both Part A and Part B coverage, which further distorts the accuracy and adequacy of the benchmark.

Calculate Benchmarks Using Only Data from Individuals with Both Medicare Part A and Part B

- MedPAC recommends CMS calculate Medicare Advantage benchmarks using only data from FFS Medicare enrollees with both Part A and B to improve accuracy. MedPAC reported that this change would likely result in a nationally-averaged 1% increase in Medicare Advantage payment and impacts would vary by county.
- If this change were enacted, areas with 20% or more FFS Medicare beneficiaries in only Part A would have significant benchmark increases. These areas include: Pittsburgh, Denver, Albuquerque, Portland, Oregon, Hawaii, and certain counties in California.
- Medicare Advantage continues to grow faster than FFS Medicare as more beneficiaries choose to get their care through Medicare Advantage. Ensuring the accuracy of the Medicare Advantage benchmark calculation is critical because this issue impacts the resources available to care for Medicare beneficiaries.
- Calculating Medicare Advantage benchmarks using only data from FFS Medicare enrollees with both Part A and B would make benchmarks more accurate and could increase beneficiaries access to affordable care, plan choices, and supplemental benefits.