

BETTER MEDICARE

ALLIANCE

THE 2017 ADVANCE NOTICE FOR MEDICARE ADVANTAGE WHITE PAPER

INTRODUCTION: On February 19, 2016 the Centers for Medicare & Medicaid (CMS) released the Medicare Advantage (MA) 2017 Advance Notice, sometimes called the “45 Day Notice,” which includes methodological changes for calendar year 2017 for MA capitation rates, payment policies (for MA and Part D), as well as other policies and information in what’s called the “Call Letter.” The Final Notice will be released 45 days after the Advance Notice, on April 4, 2016. This primer summarizes key elements in the 2017 Advance Notice for our Better Medicare Alliance (BMA) allies.

BACKGROUND: In addition to Traditional Fee-For-Service Medicare (FFS), Medicare beneficiaries have the option to choose MA and receive their benefits through a private health insurance plan. Currently, over 17 million Medicare-eligible individuals, or 32% of Medicare, receive their coverage through MA. Unlike FFS, which pays on a per service basis, MA is paid a specific monthly capitated amount for each of its beneficiaries. This capitated amount is calculated using many factors, including county level FFS data, demographics, illness, and quality. In addition, there are many policies in the MA program to facilitate quality, accurate risk adjustment, and equity. The proposed regulation that was released on February 19 is the annual update to the factors within the payment rate calculation, such as payment growth rates and demographic trends, as well as updates to the various policies within MA and proposals of new policies.

UPDATED MA GROWTH RATE

SUMMARY: MA payment is calculated using benchmarks that, after changes in the Affordable Care Act (ACA), are now set in each county based on FFS spending in that county. The benchmarks are adjusted annually based on the growth rate in FFS (among other factors). MA health plans bid against this benchmark, and if they bid below the benchmark they are able to apply a portion of that “rebate” amount to additional benefits for beneficiaries. The Advance Notice only provides a nationally-averaged MA Growth Rate. CMS will publish the specific benchmarks for each county in the Final Notice.

ADVANCE NOTICE PROPOSAL: The nationally-averaged estimated effective MA Growth Rate for 2017 is +3.0%. This estimate will likely change slightly in the Final Notice. This is roughly in line with the preview CMS gave in December and is lower than last year’s final MA Growth Rate update of +4.2%.

RISK ADJUSTMENT MODEL CHANGES

SUMMARY: In order to risk adjust accurately, CMS determines a unique risk score for each beneficiary based on his/her demographics, socio-economic status, and burden of disease. Health plans make bids in each county using the benchmark and then that base payment is adjusted based on each beneficiary’s risk score. The CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model is used to create a risk score by using the health of patients to predict how much that patient may cost in the following year. CMS has raised concern that the model is not sensitive enough to fully predict the costs needed to care for individuals dually eligible for Medicare and Medicaid. The dual eligible population can be divided into “fully dual eligible” and “partially dual eligible” individuals on the basis of the Medicaid benefits that individuals are eligible to receive (based primarily on income). Roughly 20% of the 9 million dual eligible individuals in Medicare are deemed “partially dual eligible.”

ADVANCE NOTICE PROPOSAL: CMS is proposing to implement a new CMS-HCC risk adjustment model for 2017 that creates subsegments based on age and Medicaid status. Under the new methodology, CMS would divide beneficiaries into six groups: 1) Full benefit dual aged; 2) Full benefit dual disabled; 3) Partial benefit dual aged; 4) Partial benefit dual disabled; 5) Non-dual aged; and 6) Non-dual disabled. The proposal will increase risk scores for individuals with full dual benefits and decrease risk scores for partial dual eligible and non-dual eligible individuals. CMS also proposed other technical tweaks to the model. CMS estimated all the changes to the CMS-HCC risk model would have an estimated -0.6% impact on nationally averaged MA payment year over year.

CODING INTENSITY ADJUSTMENT

SUMMARY: The coding intensity adjustment in MA is a mandatory annual reduction in MA risk scores to account for what CMS describes as the coding pattern differences between MA and FFS. This adjustment reduces all risk scores in MA by a certain percentage.

ADVANCE NOTICE PROPOSAL: CMS proposed a coding intensity adjustment increase for 2017 that reflects the statutory minimum of 0.25 percentage points required under the ACA. Thus, CMS' proposed MA coding intensity adjustment for 2017 is -5.66% . This compares to -5.41% in 2016.

ENCOUNTER DATA AS DIAGNOSIS SOURCE

SUMMARY: In 2012, CMS began collecting Encounter Data from MA. This data includes diagnosis and treatment data for all services and items provided to a MA beneficiary. For 2016, CMS initiated a transition to using Encounter Data as a data source for calculating risk scores. CMS decided to blend the current system that uses diagnosis code submissions (Risk Adjustment Processing System) and FFS data with the new encounter data to create a weighted risk score — 2016 risk scores were weighted 90% to the previous system and 10% to the new Encounter Data System. CMS signaled that it plans to continue to move to the Encounter Data System as a diagnosis source for risk adjustment.

ADVANCE NOTICE PROPOSAL: For 2017, CMS proposed to increase to a 50/50 blend of the old and new systems. CMS did not provide an analysis on the potential impact this change will have on risk adjustment in 2017, nor did it present any impact analysis on the change implemented in 2016. There have been concerns raised by stakeholders about the operability of the new Encounter Data System.

STAR RATINGS SYSTEM CHANGES

SUMMARY: Health plans are awarded Star Ratings between 1 and 5 based on performance on certain quality measures in the Star Rating system in MA. If a health plan receives 4+ stars, it is eligible for a Quality Bonus Payment (QBP) that increases the amount of payment it receives to provide care for its beneficiaries. Star Ratings also help consumers determine the quality of MA options. CMS is concerned that the current Star Ratings methodology disadvantages plans serving a high percentage of enrollees who are dually eligible for Medicare and Medicaid. CMS has been studying this correlation and put forth two proposals for consideration by stakeholders in the fall as a potential interim solution while it continues to develop more major changes to the Star Rating system.

ADVANCE NOTICE PROPOSAL: CMS presented analysis of the two proposals and is proposing to implement one, called a Categorical Adjustment Index (CAI) adjustment, which is related to each plan's proportion of dual eligible beneficiaries, and/or enrollees receiving the low income subsidy, and individuals with disabilities. CMS reported it expects this change will not have a large impact on overall Star Ratings. It estimates it will raise 11 contracts, impacting roughly 278,000 enrollees, and will move one contract down in rating; that contract has since been terminated. This change would be an interim adjustment to the Star Rating system while CMS continues to design more comprehensive methodological changes to the system.

MA EMPLOYER PLAN PAYMENT CHANGE

SUMMARY: Roughly 3 million retirees receive their Medicare coverage via MA employer plans, also called Employer-Group Waiver Plans (EGWPs). Beneficiaries covered under EGWPs currently make up 19% of MA. EGWPs allow employers to provide more comprehensive and coordinated coverage to retirees, while waiving certain MA bid requirements. EGWPs differ from non-employer plans in a number of ways, most notable is the fact that they more often involve PPOs (rather than HMOs) and that they typically cover a much broader region and provider network. CMS has expressed concerns about the competitiveness of bids submitted by EGWPs as compared to non-employer plans.

MA EMPLOYER PLAN PAYMENT CHANGE (CONTINUED)

ADVANCE NOTICE PROPOSAL: CMS is proposing to terminate the current bid submission process for EGWPs and replace it with set payment amounts for EGWPs in each county. These payment rates would be based on an enrollment-weighted county bid to benchmark ratio calculated using non-employer data. The new formula would not change the Star Rating bonuses for EGWPs, but it would change some of the guidelines around how EGWPs provide additional benefits. The change is expected to decrease payments to EGWPs. CMS stated that it plans to release the impact analysis of this change in the Final Notice, or perhaps before. Previous analyses of this policy change raise concern that the proposed methodology changes do not capture all the plan design, geographical, and other differences between non-employer and employer MA plans.

CONCLUSION: Stakeholders have until 6:00 p.m. ET on March 4, 2016 to formally submit comments to CMS. These submissions can include comments, questions, and suggestions. During the comment period and leading up to the Final Notice on April 4, Better Medicare Alliance (BMA) and other advocacy organizations will submit constructive comments and encourage policy makers to finalize policies that support the high quality care MA is providing for Medicare beneficiaries.

Better Medicare Alliance (BMA) is the leading coalition of nurses, doctors, health plans, employers, aging service agencies, advocates, retiree organizations, and beneficiaries supporting Medicare Advantage. Medicare Advantage offers quality, affordability and simplicity, with enhanced benefits to more than 17 million Medicare beneficiaries across America. BMA works to ensure the sustainability and stability of Medicare Advantage through information, research, education, and united support among stakeholders to strengthen this important coverage for seniors and people with disabilities.