KEY TAKEAWAYS

MA plans provide high-quality health care to 17 million enrollees. They address the unique needs of low-income and other vulnerable individuals and reduce costs for these beneficiaries while spurring innovations that lower traditional Medicare spending and providing the model for delivery system reforms across the program.

On Feb. 19, CMS will issue the 2017 Advance Notice and Draft Call Letter, which include the agency’s proposed payment policies for the Medicare Advantage (MA) program.

These proposals will address key issues for MA plans, including growth rates, risk adjustment, and the Star Ratings system.
Background

The Centers for Medicare & Medicaid Services (CMS) will release the 2017 Advance Notice of Methodological Changes (the 45-Day Notice) and Draft Call Letter for Medicare Advantage (MA) and Part D plans on Feb. 19, 2016. The proposals include the agency’s payment policies for 2017 and will likely address several issues of critical importance to MA plans.

ACA Funding Cuts

The Affordable Care Act (ACA) established a new methodology for calculating MA payment benchmarks in each county, which reduced funding to the program. Phase-in of this new methodology began in 2012 over a two-, four- or six-year period based upon the estimated impact of the ACA changes in the county. Counties being phased in over two- and four-year periods have fully transitioned to the new methodology.

The remaining counties (pictured below in orange) will continue to experience ACA-related cuts in 2017. Almost one-third of all MA enrollees live in these counties, which include New York City, Philadelphia, Houston, Dallas, San Antonio, and several areas in California (Riverside, Santa Clara, and Alameda counties). These continued cuts are likely to reduce overall program funding by about 0.5 percent in 2017.

County Transition Periods to ACA MA Rates
Growth Rates

Currently, CMS calculates two growth rates to determine MA county rates. This is because of the phase-in of the new ACA rates occurring from 2012 – 2017. These growth rates are only one component of the many factors affecting MA payment. During the phase-in period, the county rate is a combination of amounts determined under the ACA payment system and the system in place prior to enactment of the law. Different growth rates apply to the pre-ACA and ACA components of MA rates.

In December 2015, CMS announced preliminary estimates of the two growth rates. It is important to note the estimated growth rates announced in December 2015 are very preliminary and subject to change both in the 45-Day Notice and in the Final Rate Notice to be released on April 4th, 2016 (see chart below showing how estimates compared to final growth rates in recent years). The estimate for the fee for service (FFS) Growth percentage (also referred to as the change in the FFS USPCC) that is used to calculate rates under the ACA payment system is +3.10 percent. The estimate for the National Per Capita MA Growth percentage (also referred to as the change in the Total USPCC) that is used to calculate rates under the pre-ACA payment system is +2.56 percent. To determine the impact on the MA program, these growth percentages are often combined to calculate an overall “MA Growth Rate,” which would be approximately +3.07 percent. The MA Growth Rate will be heavily weighted to the FFS USPCC in 2017 because most of the ACA payment methodology has been implemented.

### Comparison of Preliminary Growth Rates Announced in December to the Estimated Rates Released in the 45-Day Notice and Final Rates Announced in April

<table>
<thead>
<tr>
<th>Payment Year</th>
<th>Rate</th>
<th>December Release</th>
<th>45-Day Notice (Feb)</th>
<th>Final Rate Notice (Apr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>Combined</td>
<td>-0.31%</td>
<td>-1.90%</td>
<td>-3.40%</td>
</tr>
<tr>
<td></td>
<td>Total USPCC</td>
<td>-1.98%</td>
<td>-3.55%</td>
<td>-4.07%</td>
</tr>
<tr>
<td></td>
<td>FFS USPCC</td>
<td>0.14%</td>
<td>-1.65%</td>
<td>-3.30%</td>
</tr>
<tr>
<td>2016</td>
<td>Combined</td>
<td>2.11%</td>
<td>1.70%</td>
<td>4.20%</td>
</tr>
<tr>
<td></td>
<td>Total USPCC</td>
<td>2.45%</td>
<td>2.68%</td>
<td>5.04%</td>
</tr>
<tr>
<td></td>
<td>FFS USPCC</td>
<td>2.02%</td>
<td>1.47%</td>
<td>4.08%</td>
</tr>
<tr>
<td>2017</td>
<td>Combined</td>
<td>3.07%</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td>Total USPCC</td>
<td>2.56%</td>
<td>TBD</td>
<td>TBD</td>
</tr>
<tr>
<td></td>
<td>FFS USPCC</td>
<td>3.10%</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Risk Adjustment

The goal of risk adjustment is to cover the costs of providing covered benefits for MA enrollees, including those with complex conditions. MA plans that enroll more individuals with complex conditions receive payments that more accurately reflect costs of addressing their needs. CMS has established a model that uses Hierarchical Condition Categories (HCC) to calculate risk adjusted payments. The agency selects diagnoses for the model based on their importance in predicting costs of care and makes periodic changes to more appropriately reimburse MA plans.

CMS made significant changes to the model in 2014, with full implementation in 2016. The changes eliminated early stages of certain conditions, such as chronic kidney disease and diabetes, because of concerns about coding intensity (discussed below). Funding to the program was reduced by 2.5 percent compared to the prior model and directly affected plan programs that are transforming the health care system by detecting conditions at their earliest stages and preventing their progression.

In November 2015, CMS proposed a new segmented risk adjustment model for 2017 intended to increase risk scores for “full dual eligibles” (Medicare beneficiaries with low income qualifying for the full range of Medicaid benefits) while reducing these scores for “partial dual eligibles” (Medicare beneficiaries qualifying for premium and cost-sharing support for Medicare benefits) and non-dual eligibles. The agency has observed the current model may under-compensate for costs incurred by full dual eligibles and individuals with disabilities.

AHIP strongly supports policy changes to ensure payment models sufficiently support MA plans focusing on beneficiaries with complex needs, including dual eligibles. However, we will oppose changes that reduce the overall funding for the program, particularly after the recent payment cuts, which are inconsistent with the goal of promoting stability for beneficiaries enrolled in MA plans.

Coding Intensity

The coding intensity adjustment accounts for differences in coding practices between MA and FFS. The adjustment is tied to the MA risk adjustment system, which relies upon MA plan reporting of diagnostic information obtained from health care providers to determine the health status of each enrollee.

The ACA established a mandatory minimum adjustment starting in 2014, which was increased by the American Taxpayer Relief Act of 2012 (ATRA). Under current law, the minimum coding intensity adjustment for 2017 will be 5.66 percent. CMS has the discretion to establish a higher coding adjustment, but to date, the agency has applied the minimum coding intensity adjustment required by law.

Several recent analyses have suggested the coding intensity adjustment should be higher than is currently applied by CMS. AHIP will strongly oppose increases to the adjustment above the statutory minimum amount. These proposals could reduce MA funding by up to 3 percent. Increasing the coding intensity adjustment is inconsistent with advances made by the program that are moving the health care system forward. There is evidence of undercoding in the traditional program that could lead to the failure to diagnose and treat chronic conditions. MA plan coding activities support plan programs not present in FFS that reduce unnecessary hospitalizations and improve the lives of the 17 million beneficiaries enrolled in the program. CMS’ focus on coding differentials also fails to account for savings (such as lower hospital utilization) that the FFS program has realized based on the “spillover” of MA plan practices in areas with high MA plan penetration.
Health Risk Assessments

The Medicare Payment Advisory Commission (MedPAC) has recently raised concerns that MA plans are identifying diagnoses during in-home health risk assessments (HRA) that are not subsequently confirmed during a clinical encounter with a physician or other medical professional. The Commission is recommending these diagnoses not be considered for calculating MA plan risk scores moving forward. CMS previously raised concerns about HRAs and issued a proposal similar to MedPAC’s; a previous analysis found this proposal could reduce MA funding by 2 percent.4

AHIP has significant concerns with this proposal. HRAs often identify beneficiary conditions requiring placement in an MA plan disease management program or other treatment that may not be evident in the beneficiary’s medical record. A recent Health Affairs article finds MA plans reduced inpatient hospitalizations by up to 14 percent compared to FFS by conducting in-home HRAs and implementing treatment programs for conditions identified during these visits.5 A proposal that limits HRAs also could limit MA enrollee access to preventive services, which is inconsistent with the agency’s goal to expand such services. AHIP and its members have proposed standards for HRAs that address the concerns CMS and others have raised while continuing to support MA plan activities to detect chronic diseases. Our recommendations would ensure an HRA is performed by a medical professional acting within his or her scope of practice, the HRA includes the clinical components of the Annual Wellness Visit currently offered to FFS beneficiaries and also required to be offered to MA beneficiaries, a summary of findings and proposed plan of care is provided to the beneficiary and his or her doctor, and follow-up efforts are monitored to close any identified gaps in care.

Uncertainty

MA plans are facing two issues adding to the uncertainty of the payment environment.

Encounter Data: CMS has been working with MA plans over the past several years to collect encounter data. Encounter data is similar to claims-based data collected by the FFS program. However, since MA plans are reimbursed by CMS on a capitated basis, the agency has not traditionally collected this information from health plans, which have developed their own processes to record and document transactions with providers. There have been several complications with implementing encounter data collection. For example, ongoing system issues continue to prevent capture of the full stream of diagnoses by the Encounter Data System (EDS).

CMS requires that a plan’s risk score be based on encounter data for the first time with 2016 payment, when these data will comprise 10 percent of MA plans’ risk adjustment scores. The agency could propose to increase the percentage of risk scores calculated with encounter data for 2017. AHIP would have concerns with this approach. CMS recently released its “filtering logic” for encounter data, which is fundamental to the determination of MA payments by including rules for acceptable diagnosis codes for calculating risk scores. We are concerned the filtering logic will reduce diagnoses recognized by the agency. It would be inappropriate to increase the percentage of the risk score determined by encounter data until this logic has been vetted and tested by MA plans and the impacts are fully understood.

Implementation of ICD-10: MA plans were ready for ICD-10 long before the implementation date – Oct. 1, 2015. However, it is not clear whether all of the plans’ contracted providers were as prepared. CMS gave flexibility to certain providers that allows them to submit incorrect ICD-10 codes under Medicare Part B to the FFS program through September 2016 if certain
conditions are met. MA plans are concerned such practices will carry over to services for their enrollees, which means the diagnoses reported by providers to plans for the fourth quarter of 2015 (used for 2016 risk scores and payment) and for 2016 (used for 2017 risk scores and payment) could be incomplete or inaccurate.

Other Factors

**FFS Normalization:** CMS applies a factor to MA plan risk scores due to coding and population changes in the FFS program. FFS Normalization is necessary because the risk adjustment factors in the model are based on FFS data. This adjustment can either increase or decrease MA plan payments.

**Star Ratings:** CMS is also likely to release the 2017 Draft Call Letter on Feb. 19, 2016, which will include proposed changes to the Star Ratings system. Plans that attain certain Star Ratings receive increases to their benchmark rates and higher rebate percentages for additional benefits or reduced cost sharing for their enrollees. MA plans have raised concerns that the current Star Ratings system disadvantages plans focusing on low-income populations. In response, the agency offered two potential approaches to addressing this concern in late 2015. CMS has not yet provided sufficient information to fully evaluate these proposals. AHIP will be providing additional input once this information is available.

Another Star Ratings-related issue facing MA plans is the ACA provision capping county rates at no more than the amount of the rate calculated under the pre-ACA methodology. This “ACA Cap” is most likely to affect MA plans achieving at least four stars that would otherwise be receiving increases in benchmarks due to high performance on the Star Ratings system. The cap is inconsistent with broader health system goals to reward high quality performance and AHIP is urging Congress to direct CMS to take action to eliminate it for plans earning at least four stars.

Conclusion

Innovations developed by MA plans are improving health care quality, addressing the unique needs of low-income and other vulnerable individuals, reducing costs for beneficiaries, and providing the model for reforms across the Medicare program. AHIP will strenuously oppose proposals in the forthcoming 45-Day Notice and Draft Call Letter that would reduce funding for these programs. We will support changes for 2017 that promote plan innovations that are vital to beneficiaries.

Recommendations

- CMS should not reduce funding for the MA program, which is improving care for Medicare beneficiaries throughout the program.

- CMS should implement policies that support MA plan innovations that are vital to beneficiaries, especially those with low incomes and complex needs.
Recent changes to the Medicare Advantage program could impact care delivery for millions of seniors. A 2015 report from Oliver Wyman highlights how implementing a new risk adjustment model could undermine care for patients with chronic kidney disease.

1 National Health and Nutrition Examination Study, http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5608a2.htm
3 For example, see Baiker, Katherine, Chernew, Michael, Robbins, Jacob. The spillover effects of Medicare managed care: Medicare Advantage and hospital utilization. Journal of Health Economics, Vol 32 (September 2013): 1289-1300.