2017 ADVANCE NOTICE: CHANGES TO MEDICARE ADVANTAGE PAYMENT METHODOLOGY AND THE POTENTIAL EFFECT ON MEDICARE ADVANTAGE ORGANIZATIONS

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Introduction

On February 19, 2016, The Centers for Medicare & Medicaid Services (CMS) released the Advance Notice of Methodological Changes for Calendar Year 2017 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies (the 2017 Advance Notice). This notice outlines the planned changes to Medicare Advantage (MA) capitation rates applied under Part C for CY 2017 and other regulatory changes that will affect plan reimbursement. Based on information released in the 2017 Advance Notice and reductions already being implemented by the Affordable Care Act (ACA), Medicare Advantage Organizations (MAOs) are likely to experience payment reductions for 2017. Such reductions, coupled with the reductions experienced in 2014 through 2016, could have a significant impact on the sustainability of MAO program participation and the ability of MAOs to provide stable benefits and affordable premiums to their members.

Based on the 2017 Advance Notice and the implications of the ACA payment reductions, America's Health Insurance Plans (AHIP) engaged the Actuarial Practice of Oliver Wyman to evaluate the impact of these potential changes in 2017. In this document, we describe and estimate the value of the changes reflected in the 2017 Advance Notice along with those being implemented due to the ACA.

Executive Summary

Based on our analysis, we estimate that the payment policies proposed in the 2017 Advance Notice, in combination with the continued phase-in of the ACA cuts, other legislative and regulatory cuts, in addition to the significant cuts that occurred in 2014 through 2016, could result in a high degree of disruption in the MA market. This includes the potential for plan exits, reductions in service areas, fewer benefits, provider network changes, and MA plan disenrollment due to declines in plan value from 2014 to 2017. Our findings are shown in the table below:

- We estimate that MA plans will see a reduction in payment between 0.5% and 3.9% in 2017. This impact is likely to vary among MAOs and some MAOs are likely to experience payment changes in excess of this amount. These reductions can be expected to negatively impact the benefits for beneficiaries who are enrolled in Medicare Advantage.

Estimated Reduction in 2017 for MAOs

	Impact (%)	Impact (%)
	CMS Estimate	**OW Estimate**
ACA Impact for 2017	-0.80%	-0.80%
Change in plan's Star Rating for 2017	0.10%	0.10%
Coding Intensity Change for 2017	-0.25%	-0.25%
CMS-HCC Risk Model Revision for 2017	-0.60%	-2.10%
Fee-for-Service Normalization Factor	-0.1%	Included in Risk Model Estimate Above
Change from RAPS to EDS data submission	Not Included	0.00% to -3.00%
Ratebook Change for 2017	3.00%	3.00%
Change to EGWP Payment Policy	Not Included	-0.48% to -0.86%
Total Impact for 2017	**1.35%**	**-0.50% to -3.90%**

Changes to Payment Methodology for 2017

Effective Growth Rate and Transition to ACA Rules for 2017

The ACA[1] made several changes to how MAOs are reimbursed by CMS. In 2012, the ACA began to phase-in benchmarks calculated as a percentage of per capita fee-for-service (FFS) Medicare spending. County benchmarks are ultimately set at 95%, 100%, 107.5%, or 115% of CMS' projected FFS spending, with higher percentages applied to counties with the lowest FFS spending. The phase-in has taken place over two to six years depending on the county; 2017 will be the sixth and final year of the phase-in, thus all county benchmarks will be calculated using the ACA methodology in 2017. Similar to CMS, we estimate that the impact of moving benchmarks to percentages of FFS costs will be a total reduction in MA plan payment benchmarks of **-0.8%** for 2017. This estimate also reflects the cap limiting MA rates to no higher than the amount calculated under the pre-ACA methodology.

The ACA payment methodology also varies benchmarks based on plan quality, with higher benchmarks paid to MAOs achieving higher quality ratings. Starting in 2012, plans with at least a 4.0 Star rating on a 5.0 Star quality rating scale receive an increase in their benchmark. New plans or plans with low enrollment also qualify for a benchmark increase. The ACA payment methodology also varies plan rebates based on quality, with new rebates set at 50% (the lowest Star rated MAOs) to 70% (the highest Star rated MAOs) of the difference between the plan bid and the benchmark, where prior to 2012, rebates were 75% for all plans.

Based on data available from CMS, Oliver Wyman has calculated the effect on Star rating bonuses of average plan improvement in quality Star rating between 2016 and 2017. We expect the improvement in quality Star ratings for 2017 to increase payments to plans by **+0.1%** on average.

Changes Related to Risk Adjustment

MAOs are paid on a risk adjustment model that utilizes factors reflecting beneficiaries' health status. Diagnosis coding in traditional FFS Medicare has historically been less focused than MAO diagnosis reporting due to the lack of incentive for providers to correctly and completely code diagnoses (procedure codes rather than diagnoses form the basis for how providers are reimbursed in FFS Medicare). The MA risk adjustment model is calibrated based upon FFS costs. Starting in 2010, CMS began offsetting the effect that MAOs' efficiency in coding had on plan reimbursement by reducing MAO payments across all plans. CMS applied a 3.41% "MA coding intensity adjustment" reduction to MA plan payments in 2013. The ACA, as revised by the American Taxpayers Relief Act of 2012, increased the 2014 coding intensity adjustment by setting it at a minimum of 4.91% and mandated an annual incremental increase in the adjustment starting in 2015, and continuing into 2019, that will further reduce payments by **-0.25%** each year. It is mandated that the MA coding intensity adjustment be no less than 5.9% in 2019 and subsequent years.

The risk adjustment model is adjusted each year to reflect the level of risk score coding change inherent in FFS Medicare through a normalization factor that is applied to the CMS risk score model. The goal of this normalization factor is to adjust the results of the risk score model such that the overall average risk score across all beneficiaries is 1.000. In 2017, CMS is proposing to introduce a new model calibrated on data from 2013-2014, which is a more recent time period than the previous model (calibrated on data from 2010-2011). CMS has calculated a 2017 normalization factor for this new model of 0.993.

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[1] Formally The Patient Protection and Affordable Care Act (Pub L. 111-148) (PPACA) and the Health Care and Education Reconciliation Act (Pub L. 111-152) (HCERA)

The CMS-HCC model has historically been calibrated for two separate risk segments with separate coefficients. This approach captures the unique costs of beneficiaries residing in the community and those residing in long term care institutional facilities. For 2017, CMS is planning to replace the single community segment with six separate segments based on Medicare eligibility (i.e., aged vs. disabled) as well as on Medicaid eligibility status. The six segments are the following; full dual aged, full dual disabled, partial dual aged, partial dual disabled, non-dual aged and non-dual disabled. The revision originated because of concern that the model has, historically, not accurately reflected the risk of the dual eligible population.

Using FFS data, CMS calculated predictive ratios (a comparison of actual to predicted costs using the CMS-HCC model) for several populations with results showing that full duals have historically been underpaid by the model while partial duals and non-duals have been overpaid. The CMS predictive ratios are shown in the table below.

CMS-HCC Predictive Ratios, 2014 Model

FFS Population	1.000
Non-Dual	1.015
Dual	0.957
Full Benefit Duals	0.914
Partial Benefit Duals	1.092

Because the results clearly show a bias, CMS decided to calibrate the community segment separately for each of the six populations. The result is that plans with a high concentration of beneficiaries dually eligible for Medicare and full Medicaid benefits should realize an increase in risk score under the new model, while plans with high concentrations of partial duals and non-duals should realize a decrease in risk score.

Similar to prior model versions, the new CMS-HCC model is calibrated on FFS data and produces a 1.0 risk score when run against the FFS dataset. However, because the MA population has a different mix of duals and non-duals (as well as disabled and aged beneficiaries) than the FFS population, the new CMS-HCC model produces a different overall risk score when run against MA data. Based on independent analysis conducted by Oliver Wyman, we expect that the predictive ratios alone will produce -0.58% reduction in payments to MA plans. We note that this is similar to the -0.6% that CMS has reported.

However, the predictive ratios published by CMS, and shown in the table above, are calculated on distinct cohorts with different underlying costs (2012 FFS vs. 2014 FFS). To inform their bids, it is important for MAOs to understand how the change in model impacts payments from 2016 and 2017, thus calculated on the same membership cohort. CMS and the industry are in agreement that the demographic make-up of the FFS population is changing due to factors like the aging of the baby-boomers. Given the limited publicly available data to evaluate the model change, one can infer the overall CMS-HCC model change on 2017 payments using the relative difference in normalization factors that would be applied for 2017 payments under the old and proposed risk adjustment model. The proposed 2017 normalization factor under the new model is 0.993 and the

2017 normalization factor as reported by CMS on its February 27, 2016 actuarial user group call is 1.014. Oliver Wyman's estimate of the CMS-HCC model change is thus a reduction of **-2.1%** (-(1- 0.993/1.014)).[2]

The CMS reported risk model change impact of -0.6% appears to reflect a change in predictive ratios under the old and new model. The predictive ratios do not appear to reflect the expected change in risk scores from 2016 to 2017 under the 2014 and proposed risk adjustment models, which is what is needed to calculate actual changes in plan payments as a result of a risk model change.

Since CMS began using the CMS-HCC model, plans have submitted diagnosis codes through Risk Adjustment Processing System (RAPS) files. Starting in 2016, encounter data submitted through the Encounter Data System (EDS) will be incorporated within the final risk score for plan payments. CMS is implementing the EDS methodology over several years. In 2016, risk scores are calculated using the RAPS methodology weighted at 90% while the EDS methodology is weighted at 10%. For 2017, CMS is changing the weighting to 50% on each methodology.

There are a number of operational functions that needed to be developed and/or revised, both by CMS and by plans, to ensure a successful transition from RAPS to EDS. Based on plan feedback, CMS has not yet been able to successfully implement the full range of necessary operational changes to accomplish this goal. In addition, in December 2015 CMS released a long-awaited filtering logic for determining which diagnoses submitted by MAOs to EDS would be acceptable for risk adjustment, and there remains uncertainty about the extent to which diagnoses identified as acceptable under EDS will differ from diagnoses submitted through RAPS. Based on evidence gathered from MAOs, we estimate the reduction in payments of between **0.0% and -3.0%.**

Ratebook Changes for 2017

The 2017 Advance Notice included increases to both the 2017 National Per Capita Medicare Advantage Growth Percentage (NPCMAGP) and the 2017 Fee-for-Service (FFS) Growth Percentage. The NPCMAGP was the mechanism that CMS used in their pre-ACA benchmark changes to increase payment rates and reflects trends in total Medicare costs predicted for the upcoming year and "updates" to historical trends since 2004. CMS has been phasing in the new ACA methodology over several years. 2017 is the sixth and final year of the phase-in. CMS refers to the pre-ACA payment calculation as the "applicable amount." The pre-ACA methodology is still relevant because CMS caps benchmarks at the pre-ACA methodology. In the 2017 Advance Notice, CMS stated the NPCMAGP for 2017 is projected to be 2.92%. CMS indicated that the 2.92% increase for 2017 is comprised of 2.68% trend for 2017 and adjustments to the estimates for prior years of 0.24%. These trend factors are below MAO reported claims cost trends.

Under the ACA, MAO benchmarks are tied to projected FFS costs. The "specified amount," the new benchmark calculation under the ACA, takes into consideration both a specified percentage (95%, 100%, 107.5% or 115%) of FFS costs and the quality Star bonus for each MAO contract. CMS rebased county level FFS cost projections for 2016, which means that it recalculated its projections using a more current dataset. CMS stated that it expects to rebase county level FFS cost projections for 2017. In the 2017 Advance Notice, CMS stated that the 2017 FFS USPCC

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[2] The publicly available data that might be used to estimate the model effect on a broad cross section of the Medicare eligible population (e.g., the Medicare 5% sample data) do not contain all information required for estimating risk scores under the new model. Instead, we are left to infer the full effect from information released by CMS. In the February 27, 2016 user group call, CMS instructed MAOs that a 2017 normalization factor under the 2014 model would be 1.014.

growth percentage is projected to be 3.06%. For our analysis, we have simply increased county level FFS costs from 2016 levels because CMS has not yet provided the county level rebased FFS costs.

Based upon this initial information from CMS, we estimate the combined impact of the preliminary NPCMAGP and the FFS USPCC Growth Percentage will change MA payments by **+3.0%**. CMS will have the opportunity to revise the initial estimates based on updated information and public comment when the final rate announcement is made on April 4.

Employer Group Waiver Plans

In the 2017 Advance Notice CMS is proposing two major changes to the Employer Group Waiver Plan (EGWP) pricing. First, MAOs offering EGWP plans will no longer be required to submit bids for Part C. Plans were already not required to submit Part D bids for EGWPs.

Second, and more compelling, is that CMS is proposing to change the Part C payment policy it uses to reimburse EGWP plans. CMS states that the new methodology follows more closely with what is in place for Part D. The methodology will use individual market MA bids (non-EGWPs) to establish county level benchmarks for EGWPs. A base county level benchmark and rebate will be established, the sum of which will then be multiplied by the individual member risk score to determine payment to the MAO. EGWP benchmarks will be calculated at the county level and be announced at the time regional MA benchmarks are released (generally in late July or early August).

In 2015, about 3 million, or 19% of all MA enrollees were enrolled in EGWP plans. Based on Oliver Wyman analysis of publically available data, we estimate that the new Part C EGWP methodology will reduce payments to EGWPs by between 2.5% and 4.5%, which when distributed across the program, would reduce total funding by between **-0.48%** and **-0.86%**.

Overall Reduction Calculation

Our overall calculation of the reduction that plans face for 2017 is summarized in the table below.

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Ratebook Change for 2017	3.00%	3.00%
Change to EGWP Payment Policy	-	-0.48% to -0.86%
Total Impact for 2017	**1.35%**	**-0.50% to -3.90%**

CMS has estimated the effects of policies proposed in the 2017 Advance Notice would increase average Medicare Advantage plan revenues by 1.35%. Our analysis finds these policies would reduce average Medicare Advantage plan revenues by between -0.5% and -3.9%. The primary differences in our estimates include a greater impact of the proposed changes to the risk adjustment model, the effects of the changes to EGWP payment policy and the increased use of encounter data to calculate Medicare Advantage risk scores that CMS did not address in its estimate. Unless mitigated, these factors could have a material impact on the more than 17 million beneficiaries enrolled in Medicare Advantage plans.

Health Insurance Tax and Other Factors
Medicare Advantage plans face the possibility of other changes to payment policy that we have not included in our analysis due to the greater variability in potential assumptions and wider range of the possible results.

The "Consolidated Appropriations Act of 2016" (H.R. 2029) passed by Congress and signed into law in December 2015 includes a one-year suspension of the annual fee on health insurance (also known as the health insurance tax or HIT) for 2017. CMS did not include an estimated impact of the temporary suspension of the fee in the Advance Notice. Previous analysis from Oliver Wyman estimates that Medicare Advantage enrollees could save $350 on average in 2017 as a result of a one-year suspension of the fee.[3] Medicare Advantage plans could use the impact of the one-year suspension of the fee to moderate the effects of policy changes proposed by CMS and described above. Medicare Advantage plans, however, will need to take into account the temporary nature of the suspension of the fee when submitting bids for 2017. Should Medicare Advantage plans reflect the impact of the suspension of the fee by offering additional benefits, for example, the resumption of the fee in 2018 could create instability for Medicare beneficiaries if the suspension is not extended and any changes made in 2017 are reversed.

Other policy changes excluded from the analysis that could affect 2017 payments include:

- Changes to the calculation of FFS rates as a result of rebasing.
- The implications of implementing ICD-10, particularly given CMS flexibility for certain providers to submit incorrect ICD-10 codes under Medicare Part B to the FFS program through September 2016, which means the diagnoses reported by providers to plans for 2016 (used for 2017 risk scores and payment) could be incomplete or inaccurate.

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[3] Oliver Wyman, 2015 December 16. Available online at: http://info.ahip.org/acton/ct/4056/s-0ad8-1512/Bct/l-006a/l-006a:83/ct6_0/1?sid=qE0y2tTtz

Considerations and Limitations

The reimbursement reductions will vary considerably by market (e.g., CMS calculates FFS costs on a county level basis) and MAO. Our purpose here was to estimate reductions for all MAOs combined. The opinions and conclusions expressed herein reflect technical assessments and analyses, and do not reflect statements or views with respect to public policy.

The Actuarial Practice of Oliver Wyman was commissioned by America's Health Insurance Plans to prepare this report in response to CMS' Advance Notice of Methodological Changes for Calendar Year 2017 Medicare Advantage Capitation Rates and Part C and Part D Payment Policies. Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of anything set forth herein. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of such information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.